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FEDERAL GOVERNMENT'S RELATIONSHIP WITH AMERICAN INDIANS

HEARINGS

BEFORE THE

SPECIAL COMMITTEE ON INVESTIGATIONS

OF THE

SELECT COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

ON

MISMANAGEMENT OF INDIAN HEALTH SERVICE [IHS], DEPARTMENT OF HEALTH AND HUMAN SERVICES

MAY 15, 1989
WASHINGTON, DC

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MISMANAGEMENT OF INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

MONDAY, MAY 15, 1989

U.S. SENATE,
SELECT COMMITTEE ON INDIAN AFFAIRS,
SPECIAL COMMITTEE ON INVESTIGATIONS,
Washington, DC.

The special committee met, pursuant to notice, at 10:10 a.m. in room 216, Hart Senate Office Building, Hon. Dennis DeConcini (chairman of the special committee) presiding.

Present: Senators DeConcini, McCain, Inouye, and Daschle.

Staff present: Kenneth Ballen, Andrew Klingenstein, Sam Hirsch, Kathleen Lively, and Kathy Momot.

STATEMENT OF HON. DENNIS DeCONCINI, U.S. SENATOR FROM ARIZONA, CHAIRMAN, SPECIAL COMMITTEE ON INVESTIGATIONS OF THE SELECT COMMITTEE ON INDIAN AFFAIRS

Senator DECONCINI. The Special Committee on Investigations will come to order.

Before we begin with our witnesses this morning regarding the problems of Indian health and other areas, I do want to read a statement that Senator McCain and I have reviewed, and Senator Daschle, regarding the problem this committee has had in this investigation in its inability to acquire the necessary information from the Indian Health Service. I know Dr. Rhoades is here, and he's been someone that we have worked with in my State for many, many years, and though we have had many problems, both Senator McCain and I are quite concerned about the problems.

The committee had planned to hold hearings in two phases. The morning hearing, which we will hear soon, in just a few minutes, was to lay out the current status of Indian health and the quality of health care delivery in Indian country. This afternoon we were going to highlight the preliminary findings of our committee's investigation of IHS, with testimony from our investigators and witnesses from IHS itself.

Because of two developments that have taken place over the weekend, we have been forced to change our schedule and must plan to present our findings at a later date, after further investigation. Both of these developments are quite disturbing to me because they indicate that, unlike every other Federal agency that we have examined in this Special Committee on Investigations, the

Indian Health Service has been significantly uncooperative with our committee's investigation.

In the course of this committee's work we have examined the Bureau of Indian Affairs, the Bureau of Land Management, the Mineral Management Service, the Small Business Administration, the Department of Housing and Urban Development, the Environmental Protection Agency, the Fish and Wildlife Service, and the Bureau of Reclamation. Although the nature of our work was investigative and our ultimate findings were often critical, all of these agencies fully cooperated with our office and our investigators. They not only opened their offices to us, but have actually encouraged their employees to come forward and be interviewed.

The BIA, for example, wrote its employees early in the life of the investigation and told them of the Secretary's complete support for our work. Moreover, BIA employees were specifically told they were free to meet with our investigators in confidence, without being required to tell their supervisors. Their letter, dated June 16, 1988, also reminded employees of their rights to come forward and speak freely with members of the committee's staff.

Throughout our investigation of IHS this level of cooperation has been lacking. While the Director, Deputy Director and Associate Director for Administration and Management have all sat down with us for lengthy depositions under oath, we have had repeated difficulties with document production and access to lower-level employees.

This weekend the committee received information suggesting that a possible witness may have been subjected to pressure not to fully cooperate with the committee. We clearly need to investigate this allegation before proceeding further.

On March 2, 1989, we requested extensive documentation concerning IHS headquarters, as well as the Oklahoma City and Nashville Area Offices. We had received far-reaching allegations—and I stress that these are only allegations—that these area offices had circumvented normal Government finance and procurement procedures. We have not been able to substantiate these allegations in large part because we have not been given documents that were requested from IHS by us in early March.

On at least three occasions since that request, committee attorneys have spoken with IHS headquarters about their failure to comply with this request for these documents. On one occasion, IHS asked that we narrow our document request, and we complied with their wishes.

The only explanation the committee received as to the lengthy delay in providing documents was given in a sworn deposition before the committee by Milburn Howard Roach, Associate Director of IHS. Mr. Roach testified that IHS delayed responding to the committee's request for documents because the IHS had decided to give an "interim response that went through and found its way to the Department, but for some reason it never got out." Despite repeated questioning, Mr. Roach could not provide a clearer answer than that.

It was not until Friday evening, May 12, at 6:20 p.m., less than 72 hours before this hearing, that the agency provided us with any of the documents that we had requested. At that time we received

approximately 7,000 pages of documents. These documents came in stacks, with no index, no numbering system, and no discernible method of organization.

Accompanying those boxes of documents was a brief note from IHS Director of Legislation and Regulation which says, "As additional material is submitted I will forward it to you. I apologize for the delay." To date, this is the only written response we have received in the 10 weeks since we made our request.

No other Federal agency, or company for that matter, has ever submitted documents to us in such an incomplete, incoherent and untimely fashion. In combination with other allegations received this weekend, the only responsible action at this time is to postpone until a later date the second phase of today's hearings relating to IHS.

Senator McCain, Senator Daschle, and I have instructed our committee staff to carefully examine the new documents received Friday evening and to take further depositions under oath. In addition, we will renew our request to IHS for the remainder of the documentation that we originally requested two and a half months ago. From this point forward we will consider subpoenaing IHS for documents and testimony. Although we have refrained from serving subpoenas on other Federal agencies, the committee will use its power of subpoena if it is necessary to carry out the duties vested in us by the United States Senate.

And finally, I'd like to say that this committee has always conducted the most comprehensive and rigorous possible investigation, no matter who the target or the particular subject matter might have been. Whether it was tape recording the chairman of a tribal council or conducting covert surveillance of oil companies, our investigation staff has taken pains to produce an accurate and complete record of the evidence. In the course of our entire investigation we have received more than a million pages of documents from natural resource companies and other companies, as well as governmental agencies. Committee staff have always examined all documents before conducting questioning in public hearings.

To proceed with the questioning today without a meaningful opportunity to fully examine the documents just submitted by IHS Friday evening would be not only irresponsible, but a complete break with our past practice and procedures. We will not allow IHS to alter or compromise the quality and integrity of our investigative practices.

The Committee looks forward to its further investigation into the very important matter of Indian health. This includes, of course, the taking of further sworn testimony from the Director of the Indian Health Service, subject to complete questioning based on all the facts, and not a partial record. This morning's testimony clearly indicates there is much reason for concern in this area.

I want to yield now to the Senator from Arizona, Senator McCain.

Senator MCCAIN. Thank you, Mr. Chairman. I think your statement is a very important one, and I would, with your indulgence, just ask the Staff Director a couple of questions.

Mr. Ballen, as the Chairman said, you have not seen this kind of lack of cooperation from any other agency that this committee staff has dealt with?

Mr. BALLEN. Absolutely not. And as the Chairman indicated, Co-chairman McCain, we have dealt with a myriad of Government agencies. No agency has failed to respond to us in this matter. Either the IHS has not taken this committee's request very seriously, or it is in incredible disorganization in getting the documents to us, or there's a lack of cooperation, or all three, because no other Government agency has treated this committee in the kind of fashion, and with the lack of seriousness that the IHS has.

Senator MCCAIN. Which has in turn caused this committee to delay its proceedings and, as the Chairman said, we will not be able to have the hearing this afternoon in IHS as we had planned for some weeks, is that correct?

Mr. BALLEN. That's correct, sir. We could have a hearing this afternoon, but if we had it we would have it in a way that wouldn't have all the facts under our belt because of the way the IHS has failed to respond. We haven't done that with any other agency or company, and I don't think it would be wise to begin that kind of practice now.

Senator MCCAIN. Mr. Chairman, I'm not sure what all our options are here. I'm sure that we can examine them with staff, but frankly, I share your deep disappointment in an organization that, as you said, you and I both have had a lot of dealings with in the past years, and I hope that steps will be taken to correct this problem as soon as possible.

As you mentioned, I note Dr. Rhoades and others from IHS are in the audience. I hope they understand that we are serious.

I thank you, Mr. Chairman.

Senator DECONCINI. Senator McCain, thank you for that follow-up inquiry to the Staff Director.

Senator Daschle.

Senator DASCHLE. Mr. Chairman, I would like to associate myself with your remarks and those of the Senator from Arizona. I also am very disappointed. And frankly, I'm angry. There is obfustication, there has been stonewalling, and as you've said, there have been allegations of outright retribution against those who do want to cooperate with this subcommittee.

I share your view that the full authority that has been given this investigative committee with regard to the need to investigate ought to be used in this case, whether it's subpoenas or anything else. I fully endorse the Chairman's actions and feel strongly about the need to get to the bottom of this with the full cooperation of those in the Indian Health Service.

So I will support your actions and indeed hope we can do so with some haste.

Senator DECONCINI. Senator Daschle, thank you very much.

And let me just end by saying it is still our hope that IHS will come forward now with a cooperative effort to sit down and make arrangements that we can go through the documents in a timely manner, and not be put off so that we don't have to have a confrontation greater than what we are having this morning.

Our first witness this morning is Denise Dougherty, Senior Analyst in the Health Programs Division of the Office of Technology Assessment. Would you please come forward and raise your right hand?

[Witness sworn.]

Senator DECONCINI. Mr. Klingenstein will do the questioning.

STATEMENT OF DENISE DOUGHERTY, PH.D., SENIOR ANALYST, HEALTH PROGRAMS DIVISION, OFFICE OF TECHNOLOGY ASSESSMENT

Mr. KLINGENSTEIN. Good morning, Dr. Dougherty.

Dr. DOUGHERTY. Good morning.

Mr. KLINGENSTEIN. Dr. Dougherty, as the Chairman noted, you have a Doctorate from Boston University in Social Psychology, is that correct?

Dr. DOUGHERTY. That's correct.

Mr. KLINGENSTEIN. How long have you been with the OTA?

Dr. DOUGHERTY. Five and a half years, approximately.

Mr. KLINGENSTEIN. OTA is the Office of Technology and Assessment, is that correct?

Dr. DOUGHERTY. Office of Technology Assessment, that's right.

Mr. KLINGENSTEIN. What is that organization?

Dr. DOUGHERTY. That's a research and analytical arm of Congress, about equivalent to the GAO, the CRS.

Mr. KLINGENSTEIN. And does it, like those organizations, perform research at the request of Congress?

Dr. DOUGHERTY. That's right. In response to request from Congressional Committees we do extensive studies.

Mr. KLINGENSTEIN. Now has your office, Dr. Dougherty, agreed to help this committee conduct an analysis of Indian health?

Dr. DOUGHERTY. Yes, we have.

Mr. KLINGENSTEIN. And what is the prime basis of your testimony today, Dr. Dougherty?

Ms. DOUGHERTY. The prime basis is a study that we conducted between 1984 and 1986, that was published in 1986, called Indian Health Care. And that study was done at the request of the House Energy and Commerce Committee, and the Senate Select Committee on Indian Affairs.

Mr. KLINGENSTEIN. And you've supplemented the data for that where necessary?

Dr. DOUGHERTY. That's right. We also did a follow-up study of clinical staffing in the IHS, and I've asked in the past couple of weeks the Indian Health Service for some updated information, and your committee also provided some information on appropriations and so forth.

Mr. KLINGENSTEIN. Is it fair to say, Dr. Dougherty, that that's the most comprehensive study recently conducted on Indian health?

Dr. DOUGHERTY. Yes, I think so.

Mr. KLINGENSTEIN. Now, before we get to that study precisely, I wonder if you could briefly describe the Indian Health Service and the programs it provides?

Dr. DOUGHERTY. Okay.

I'll wait for the chart to go up there.

[Showing chart.]

Dr. DOUGHERTY. The Indian Health Service is part of the U.S. Department of Health and Human Services, and part of the Public Health Service. The main headquarters is in Rockville, Maryland, but the main activity goes on in the 12 IHS Area Offices, which oversee a number of service units. Some of those service units are run by the IHS directly, and others are run by tribal governments with contracts and grants from the IHS. About 1 percent of the budget goes for urban projects, as well.

Mr. KLINGENSTEIN. And that chart visibly describes headquarters, 12 Area Offices, and then various service units underneath those?

Dr. DOUGHERTY. Right.

Mr. KLINGENSTEIN. And it also describes some hospital and other clinics providing direct care services, is that right?

Dr. DOUGHERTY. Right. The service units are the basic unit and then many areas have hospitals and health centers and smaller clinics. There's a variety of kinds of services. But it's mostly clinical services are provided by the Indian Health Service.

Mr. KLINGENSTEIN. And what is the total current budget for IHS?

Dr. DOUGHERTY. The appropriation for fiscal year 1989 was $1.02 billion.

Mr. KLINGENSTEIN. Can you tell us what percentage, roughly, of that budget is spent on direct care, and on some of the other programs?

Dr. DOUGHERTY. Well, 86 percent of that is spent on clinical services, hospitals and clinical centers, and most of that is medical services. There's about 3 percent for dental care, 3 percent for alcoholism, and 1 percent for mental health services, included in that 89 percent.

Mr. KLINGENSTEIN. And what is meant by the term direct care, Dr. Dougherty?

Dr. DOUGHERTY. Direct care are the services that are provided by staff employed directly by the IHS. Then there's contract care, which if the IHS can't provide the service, there's a certain pool of money that can be used for services provided by other providers in the community.

Mr. KLINGENSTEIN. Okay.

Dr. DOUGHERTY. And then there's the 638 services which are provided by the tribes directly.

Mr. KLINGENSTEIN. What is the prime basis that this study used to make its conclusion?

Dr. DOUGHERTY. Well, we used a lot of data from the Indian Health Service; their health status data, which they actually get their mortality data from the National Center for Health Services; but they keep patient care information, and they have resource information about the allocation of resources within the IHS. So a lot of what's in our report, 1986 report, is based on those numbers from the IHS.

Mr. KLINGENSTEIN. The principal method by which you made a determination is on the mortality rates, is that right?

Dr. DOUGHERTY. For health status, that is the most reliable method of comparing Indian health to the U.S. general population, because there are a number of differences between the way IHS provides services and the rest of the country does.

Mr. KLINGENSTEIN. Let me ask you, before we get to your findings, whether there has been any disagreement between OTA and IHS on the presentation of your figures?

Dr. DOUGHERTY. Well, it's not that the IHS disagreed with the way we presented our figures, but the way IHS puts out a report every year, called The Chart Series, that will soon be called Trends in Indian Health, and the IHS uses National Health Center statistics from the 32 reservation States. That includes both the population that is served by the Indian Health Service and the population not served by the Indian Health Service, theoretically.

Mr. KLINGENSTEIN. And OTA used a different base on which to make it's judgment?

Dr. DOUGHERTY. Right. Since we were looking at the way the Indian Health Service was providing services, we looked at the population served by the Indian Health Service only.

Mr. KLINGENSTEIN. And they looked at the total population?

Dr. DOUGHERTY. They looked at the total population, including urban Indians, suburban Indians, anybody who identifies themselves as an Indian for the U.S. Census, or for the mortality statistics.

Mr. KLINGENSTEIN. And it is OTA's assumption in doing its statistics that way, that what you really should be concentrating on are the population actually being served by IHS?

Dr. DOUGHERTY. Yes, we thought so. And in fact, the IHS has told me that they agree with that, and that in the future they will be reporting statistics that way, because they think that's the better way to do it.

Mr. KLINGENSTEIN. Let me ask you about some of your major findings now, on the basis of those mortality statistics.

[Showing chart.]

Mr. KLINGENSTEIN. Could you describe, Dr. Dougherty, the findings that are reflected in these two charts?

Dr. DOUGHERTY. Yes. We found that there's a considerable gap between the health status of American Indians and the health status of the rest of the population taken together. That's shown most dramatically, I think, in that chart on the lefthand side, that's called Figure 8 from our report, which shows for each age group, the ratio of Indian mortality to U.S. general races mortality, all races mortality. And you can see up to age 74 that the Indian death rate exceeds that of the U.S. general population. And that's really true for the group between 15 and 44.

Mr. KLINGENSTEIN. And indeed, in one age period the death rate is more than three times that of the general population, is that right?

Dr. DOUGHERTY. That's right, for the 25 to 34 year group.

Mr. KLINGENSTEIN. I was going to ask you whether there came a period, whether there was a category of age group where the mortality rate actually falls below that of the general population?

Dr. DOUGHERTY. Yes. That's for the 75 and over age group.

Mr. KLINGENSTEIN. And why is that, Dr. Dougherty?

Dr. DOUGHERTY. Well, unfortunately, most Indians don't live long enough to make it to age 75, so that their mortality rate in that age group is lower than for the general population.

Senator MCCAIN. May I interrupt?

Dr. DOUGHERTY. Yes.

Senator MCCAIN. What are the major reasons of the deaths in that age group, 25 to 34, where it's three times the national average?

Dr. DOUGHERTY. Well, that's actually shown in that second chart. It's not by age, but that age group suffers from liver disease and cirrhosis, which actually comes later in the general population. Accidents, homicide, suicide, diabetes, there are a lot of causes of death that come either—don't come at all relatively in the U.S. population, or come much later, like heart disease.

Senator MCCAIN. Is there a high suicide rate in that 25 to 34 age group?

Dr. DOUGHERTY. Yes, there is.

Senator MCCAIN. I thought a lot of the suicides occurred was in teenagers?

Dr. DOUGHERTY. Well, it's in teenagers, too. It's in the 15 to 24 year old group.

Senator MCCAIN. It's also in the 25 to 34 group?

Dr. DOUGHERTY. Right.

Senator MCCAIN. Is it significantly higher than the national average in that group?

Dr. DOUGHERTY. I'm recalling that it is.

Senator MCCAIN. And when you say accidents, are a lot of the accidents alcohol-related traffic accidents, or do you go into that depth?

Dr. DOUGHERTY. Well, we didn't actually sort out what percent of accidents are alcohol-related. But it's believed that a large number of them are, and the IHS data actually supports that. But there are other reasons for motor vehicle accidents, and access to care may be one of the reasons why the mortality rate is higher.

Senator MCCAIN. Thank you.

Senator DASCHLE. I was going to ask a similar question, and it relates to the difficulties that you see in health care on the right, and how much of that is related directly to alcoholism? You have several of those, homicide, renal failure, accidents, liver disease, cirrhosis, that all seem in some way to be related to alcoholism. Do we know what percent of all of those cases—could one say all of them are?

Dr. DOUGHERTY. No, I don't think all of them are. But, a great percent of them are, and I think the most direct way to see that is that the death rate from liver disease and cirrhosis is four times that of the U.S. general population.

Senator DASCHLE. And that could almost entirely be attributed to alcoholism, could it not?

Dr. DOUGHERTY. Probably, almost entirely. There are other causes, but certainly the big difference is.

Senator MCCAIN. Let me go back to that one second. Have you seen any results of what we know is increased drug abuse among the Indian population?

Dr. DOUGHERTY. When we were collecting this data and doing our study, that didn't seem to be that big an issue compared to the alcohol abuse. That was the greatest proportion of drug abuse. One person remarked to me while we were out in the field, and this was supported by other people, that she felt that 100 percent of Indian families had been affected by alcohol abuse, significantly.

Mr. KLINGENSTEIN. Dr. Dougherty, to what do you attribute the high rate of those top five or six illnesses as cause of death?

Dr. DOUGHERTY. Well, actually it's called social causes of death, or external causes of death. It's not from the natural physiological processes of aging.

Mr. KLINGENSTEIN. What are external sources?

Dr. DOUGHERTY. Well, they're caused by social and economic conditions and the resulting psychological conditions from those. There's the high rate of poverty, a very, very high rate of unemployment among Indians, and that causes hopelessness and despair which can lead to drinking and drug abuse, and there have been increasing reports of child abuse on Indian reservations, as well.

Mr. KLINGENSTEIN. I wonder if you could now address what is depicted in the next charts.

[Showing charts.]

Dr. DOUGHERTY. Okay.

The chart on the left compares infant mortality rates among Indians to that of the U.S. all races population. And here I think you can see that this is one area where the Indian Health Service, I assume, has made significant improvements in Indian health, because the American Indian rate for infants from birth to a year, is just a little bit above that of the U.S. all races population. And in fact, among neonates it appears that the American Indian rate is below that of U.S. all races population.

But then when you look at that middle category there, which is postneonates, which is from one month to one year old, the American Indian rate is twice that of the U.S. all races population, which suggests that after the Indian babies go home, that they still suffer from morbidity that causes death inordinately compared to U.S. races.

Mr. KLINGENSTEIN. Let me ask you about the neonate figure. Has that rate shown improvement over the last several years, do you know?

Dr. DOUGHERTY. Well, that appears to be holding about the same.

Mr. KLINGENSTEIN. Do you have an opinion as to why that rate has improved?

Dr. DOUGHERTY. Well, from what we observed, the Indian Health Service put a lot of effort into care for infants. They made sure that Indian women got in for prenatal care on a regular basis, that's what a lot of the community health representatives are used for. When the babies are born in the hospital, they took good care of them, they made sure that Indian women were in the hospital in time to have their babies, and then immediately after birth and the babies went home, the Public Health nurses would go and visit the Indian homes and try to help instruct the mothers, and provide care. But apparently that doesn't happen after the baby gets a little bit older, probably because of the high birth rate and the need to keep track of the younger babies.

Mr. KLINGENSTEIN. And how about in the mortality rates for infants generally. That chart depicts mortality rates for them generally, look quite a bit higher by percentage points than the U.S. population generally.

Dr. DOUGHERTY. Yes.

Mr. KLINGENSTEIN. Has that rate improved or stayed the same over the last several years, do you know?

Dr. DOUGHERTY. It's stayed about the same.

Mr. KLINGENSTEIN. You noted, Dr. Dougherty, that in the first month after birth, that the Indian mortality rate is actually lower than the general population. Is that true, Dr. Dougherty, area-wide, or are there differences between areas?

Dr. DOUGHERTY. No, in my written testimony, which I hope you'll accept for the record——

Mr. KLINGENSTEIN. Certainly.

Dr. DOUGHERTY [continuing]. It shows considerable variation among the IHS areas. For example, the Aberdeen area for infants, that whole one-year-olds group, from birth to one year for the Aberdeen area, the rate is twice that of the U.S. all races population. And there are similar discrepancies among other areas, greater rates of infant mortality in the U.S. all races.

Mr. KLINGENSTEIN. Will you put up the next chart please?

[Showing chart.]

Mr. KLINGENSTEIN. Could you discuss, briefly, Dr. Dougherty, the way health care funds are allocated among area offices?

Dr. DOUGHERTY. Well, it's basically on an historical basis.

Mr. KLINGENSTEIN. What does that mean, on an historical basis?

Dr. DOUGHERTY. On an historical basis means that you get basically what you got last year, adjusted for inflation.

Mr. KLINGENSTEIN. As opposed to on the basis of——

Dr. DOUGHERTY. Of health needs, yes. Now, there has been some effort in the last couple of years to take health status into account using the new resource allocation methodology. Part of its formula uses health status as measured by mortality rates, differing mortality rates among areas.

Mr. KLINGENSTEIN. Can you comment on the allocations of health care funds to Indian population versus the general population?

Dr. DOUGHERTY. Well, it's hard to do that, because the Indian Health Service is a service delivery system, and it's hard to keep track of their costs and the way it's done for the national population is a bit different.

But, the latest information on per beneficiary personal health expenditures shows that the U.S. expenditures are about twice that of those for Indians on an overall basis. And it differs by area, again.

Mr. KLINGENSTEIN. Has the amount of public spending on Indian health adjusted for inflation, has that stayed the same over the last couple of years, or has it changed?

Dr. DOUGHERTY. Yes. That's what these two figures up here show. The one on the left shows IHS total allocations, that's the total budget. And the top line shows the increases in allocations, not adjusted for inflation, but when adjusted for inflation using

1972 dollars, the bottom line there shows that the allocations have just about kept pace with inflation.

Senator DASCHLE. May I clarify a question——

Dr. DOUGHERTY. Yes.

Senator DASCHLE [continuing]. That I have with that second chart, the one on the right. It says dollars per potential beneficiary. Are those dollars that the beneficiaries actually receive in terms of the care that they get, or does that include the administrative cost as well?

Dr. DOUGHERTY. That includes administrative costs. That's the total allocations of the Indian Health Service.

Senator DASCHLE. Earlier you said that the administrative cost was around 14 percent of the program—or at least I thought that's what your report was. Is that accurate?

Dr. DOUGHERTY. No. I tried to get the percent of the Indian Health Service budget that is for administrative costs, and it's difficult to get. They estimate that it's between 5 and 8 percent.

Senator DASCHLE. They estimate that?

Dr. DOUGHERTY. Yes. But I wasn't able to get any computer runs and everything, because that would have taken a great deal of effort.

Senator DASCHLE. Do you have any appreciation as to whether that's in the ball park or not, 5 to 8 percent?

Dr. DOUGHERTY. I really was not able to compare that to any other system of care. Sorry.

Mr. KLINGENSTEIN. Dr. Dougherty, in your study, did you look at the deferral of procedures?

Dr. DOUGHERTY. Yes. As I mentioned earlier there's a certain amount of money that's for contract health services. And that's distributed differentially among areas as well. What happens is, if an Indian person requires care for something that the IHS does not deliver directly, like providing eye glasses, or certain elective surgeries, then they have to go outside the IHS for that, and if what they need is not in the medical priority of the area, then they have to be put on a deferred services list.

Mr. KLINGENSTEIN. So you measured this on the basis of the deferred services list?

Dr. DOUGHERTY. Well, actually we couldn't measure that because there were no quantitative data when we were doing our study, but in fiscal year 1988 the Indian Health Service did start to measure how many services were deferred. And I found from them that there were about 27,000 services deferred, which they estimated would have cost a total of $33 million to provide in 1988.

Mr. KLINGENSTEIN. And do you believe that that is an accurate reflection of the total procedures that are deferred?

Dr. DOUGHERTY. Well, I haven't updated an analysis of how they figure those deferred services, but when we were doing our study, there were a lot of reasons why people would not be on a deferred services list. One of them is that you have to go to the Indian Health Service and ask for the service, and if you become discouraged because you've been on the deferred services list for several years, you may not go back and ask for that service again. And then, at that time there was a certain period where you'd only be kept on the deferred services list say for three months, and then

after that period you'd be dropped, so you'd have to go back again and ask for the service. So there may be reasons why that 27,000 services is an understatement.

Mr. KLINGENSTEIN. Such as if you got discouraged and never asked for the service again, or if you were on the deferred list and dropped and not counted?

Dr. DOUGHERTY. Right.

Mr. KLINGENSTEIN. Are you able to comment on the level of health care staffing at the IHS facilities?

Dr. DOUGHERTY. Yes, especially our clinical staffing study. We compared the staffing ratios for Indian Health Service to that of the rest of the Country. There are no national standards for staffing, but one physician per 1,000 patients is usually the rule of thumb. And in metropolitan areas there are as many as almost two physicians per 1,000 population. But for the IHS it's 0.7 physicians per potential beneficiary in the IHS service area. And that varies from area to area, again. With the Aberdeen area having only 0.4 physicians per thousand population, and having the heaviest workload.

Mr. KLINGENSTEIN. Aberdeen has the heaviest workload?

Dr. DOUGHERTY. Right. That's what we found in 1985.

Mr. KLINGENSTEIN. Does Aberdeen also have the highest, or one of the highest, mortality rates, do you know?

Dr. DOUGHERTY. That's right. It has the highest mortality rate, which is 2.2 times that of the U.S. all races population.

Senator DASCHLE. Are you saying the Aberdeen area has the highest mortality rate, and the worst set of statistics across the board, but the least number of personnel in providing service?

Dr. DOUGHERTY. It wasn't the least, but it was—well, right, the clinical workload was the highest.

Senator DASCHLE. Clinical work was the highest and the number of personnel allocated to the Aberdeen area is the least?

Dr. DOUGHERTY. It's not the least, but——

Mr. KLINGENSTEIN. One of the least?

Dr. DOUGHERTY. One of the least. It's far below—it's half that of the IHS average.

Senator DASCHLE. It's half of the average?

Dr. DOUGHERTY. Yes.

Mr. KLINGENSTEIN. I'm going to ask you about your personal observations on the reservations, in a moment. But could you sort of conclude as to your findings in this area, what the level of Indian health—or what the status of Indian health is?

Dr. DOUGHERTY. Yes. Well, we did find some improvement over time in mortality statistics, which were the ones we used as a benchmark. But there remains an alarming disparity between the U.S. general population and the Indian population in terms of health.

Mr. KLINGENSTEIN. An alarming disparity from outside the first month of birth?

Dr. DOUGHERTY. Yes.

Mr. KLINGENSTEIN. Now, in the course of your study you went out to the field and made field visits, observed these service units and hospital facilities in operation, is that correct?

Dr. DOUGHERTY. That's right. And we had meetings in each area to which all Indians were welcome to come and give us their impressions of what was going on.

Mr. KLINGENSTEIN. How many of those areas did you cover, approximately?

Dr. DOUGHERTY. We had about seven meetings all together. We went to all western areas. We went to the Northwest, California, Alaska, the Southwest, around Minnesota.

Mr. KLINGENSTEIN. Could you give us your comments as to what you observed?

Dr. DOUGHERTY. Yes. We observed, when we went around to the different health facilities, we observed outdated facilities, people standing, waiting to get services, not enough chairs in the waiting rooms, very young physicians. The IHS has to depend on a lot of people who are just getting out of medical school. And a lot of people with serious, heartbreaking health problems would come up and talk to us, or we'd go and talk to them.

Mr. KLINGENSTEIN. Thank you, Dr. Dougherty.

Dr. DOUGHERTY. You're welcome.

Mr. KLINGENSTEIN. That concludes my questions.

Senator DECONCINI. Senator McCain, do you have any questions?

Senator MCCAIN. Yes, thank you, Mr. Chairman.

We appreciate this study, and I think it helps us a great deal. Let me just ask, the allocations per potential beneficiary, part of that has to do with the dramatic increase in population, isn't that right?

Dr. DOUGHERTY. That's right. There is an increase in population.

Senator MCCAIN. A rather significant increase, I think in birthrate on our Indian reservations.

Dr. DOUGHERTY. There's a high birthrate, and then there are sometimes new tribes being made eligible for Indian Health Services.

Senator MCCAIN. In reading your testimony it seems that part of the problem is a lack of concentration of health services where the greatest need exists, is that accurate?

Dr. DOUGHERTY. That's what people told us, and when you look at the numbers that certainly seems to be the case, yes.

Senator MCCAIN. Did you have a chance to look at where the personnel is distributed as far as percentages here in Washington and Rockville, as opposed to at places like Window Rock and Ft. Defiance?

Dr. DOUGHERTY. No, we didn't.

Senator MCCAIN. Maybe in your next study you could have a look at that.

Dr. DOUGHERTY. Okay, sure.

Senator MCCAIN. Thank you very much.

Dr. DOUGHERTY. You're welcome.

Senator DECONCINI. Senator Daschle, do you have any questions, and also did you have a statement you wanted to enter into the record?

Senator DASCHLE. Mr. Chairman, with your approval I'll submit it for the record.

Senator DECONCINI. Without objection, the Senators from South Dakota, as well as my opening statement, will go in the record.

[Prepared statements of Senator DeConcini and Senator Daschle appear in appendix.]

Senator DECONCINI. Senator Daschle.

Senator DASCHLE. Dr. Dougherty, what is the death rate for those Indian people between the ages of 15 and 44?

Dr. DOUGHERTY. Well, as that chart showed, it's about three times that of the U.S. all races population.

Senator DASCHLE. I don't have the chart in front of me. What figure was that?

Dr. DOUGHERTY. I'm sorry, I don't have those rates in front of me, either.

Senator DASCHLE. What percent of Indians actually die during those years? That's the question I'm asking.

Dr. DOUGHERTY. Well, 37 percent of Indians are likely to die, or did die when we looked at the numbers, 37 percent died before age 45, compared to 12 percent of U.S. all races population dying before age 45.

Senator DASCHLE. Thirty percent——

Dr. DOUGHERTY. Thirty-seven percent.

Senator DASCHLE. Thirty-seven percent Indian, twelve percent non-Indian?

Dr. DOUGHERTY. Right.

Senator DASCHLE. So you have a 300 percent greater chance of dying if you're Indian?

Dr. DOUGHERTY. Before the age of 45, that's right.

Senator DECONCINI. What percent?

Senator DASCHLE. Three hundred percent, a greater chance.

That's a phenomenal statistic. And I think that says it all.

You mentioned in your answers earlier, that alcoholism treatment represented about 3 percent of the Indian Health Service budget. I asked the question earlier regarding the diseases and the percent of diseases as it compared to other people as they relate to alcoholism, only because I'm startled that given the pervasiveness of alcoholism and the relevance that alcoholism has to so many of the diseases that only 3 percent of the entire health service budget is allocated for alcoholism and treatment.

First of all, as you have investigated their budget, do you find any explanation for that low level of funds attributed directly to the treatment of alcoholism? And, secondly, as you look at this problem, is that part of the problem, that we're not allocating the budget properly to address some of the consequences of alcoholism more appropriately as you see on the chart on the left?

Dr. DOUGHERTY. Yes. To answer the first part—what was the first question?

Senator DASCHLE. Have you found any explanation as to why it is only 3 percent?

Dr. DOUGHERTY. Okay.

I think part of the explanation is that the alcoholism treatment budget follows the same historical pattern as the clinical services. And——

Senator DASCHLE. But if I could stop you just a second. You said the historical pattern is just that they take what they spent last year and then add to it——

Dr. DOUGHERTY. Yes.

Senator DASCHLE [continuing]. Taking into account the inflation?

Dr. DOUGHERTY. Right.

Senator DASCHLE. That doesn't seem much of an explanation as to why they're spending it as they are, just that they've done it in the past that way.

Dr. DOUGHERTY. Well——

Senator DASCHLE. Is that the best answer they can give us?

Dr. DOUGHERTY. I think so. At a certain point the NIAAA turned over the alcoholism treatment grants to the IHS and different areas, or different tribes had different allocations for alcoholism treatment, and that's basically continued. The agreement was to continue that pattern over time. And that has basically continued.

But I think, as you can see, if the allocations per beneficiary remain about the same, then there's not much room for moving around in the different areas. That could be one explanation and between that and the mental health budget it does seem very underfunded.

Senator DASCHLE. I personally am extraordinarily disturbed by this lack of appropriate allocation. We've talked in the past in committee hearings about this, and I would hope that at some point in the future we might find a better explanation, and if there is no better explanation for, say, reallocation of priorities to take into account what's happening here, and the basis for that occurrence.

With regard to the allocation of personnel, I'm troubled by what you said about Aberdeen. How are decisions made with regard to where personnel are currently sent? Do you have any understanding of the assignment system used in IHS?

Dr. DOUGHERTY. Well, to be fair to IHS, I think they have tried to get people to the Aberdeen area. But it's very difficult to get people to go there, and I think because of the high health needs of the population, and the fact that they are going to be overworked, if more people aren't brought and with the poor living conditions, it is difficult to get people to work in the Aberdeen area.

But I assume that the personnel allocations follow along the same lines as the resource allocations in general, which is historical funding.

Senator DASCHLE. In other words, just whatever we've done in the past, once again?

Dr. DOUGHERTY. With probably some effort to get people to the more underserved areas. I think there is effort to get people to those areas.

Senator DASCHLE. But with not much success, correct?

Dr. DOUGHERTY. Apparently not.

Senator DASCHLE. One last question, Mr. Chairman, that relates to the allocation of personnel at national headquarters. It's been reported to me with some frequency that the allocation of personnel in Rockville is inordinately high, that the number of personnel actually located in Rockville is substantially higher than what it ought to be. I have no basis upon which to make a judgment about that, and I would wonder if you would?

Dr. DOUGHERTY. I really don't, Senator. Sorry.

Senator DASCHLE. Thank you, Mr. Chairman.

Senator DECONCINI. I'm very pleased the Chairman of the Select Committee on Indian Affairs has joined us. Senator Inouye, do you have any questions or any comments?

Senator INOUYE. No questions.

Senator DECONCINI. Dr. Dougherty, let me ask you in your statement, and I join Senator McCain in my compliments for a comprehensive statement that you've given us, you talk about 7 percent of IHS budget was used for preventive health services. Do you have any comparison with private sector or other public health as it relates to prevention, or do you know?

Dr. DOUGHERTY. I don't know. It's difficult to do that. It's hard to compare the Indian Health Service to anything else.

Senator DECONCINI. Well, if you have a military health service or something, have you ever seen any comparisons to what the Department of Defense uses in prevention?

Dr. DOUGHERTY. No, I haven't.

Senator DECONCINI. Also, you do bring out one of the obvious things, I think, that is a constant concern here on the Hill, and you underscore the budgetary problems that IHS has encountered and does encounter. Have you—and maybe your information here might provide this, but I did not see it. Have you done any comparisons with the growth in the—first, do you know, or does your study, or do you have access to what IHS—and we may have to ask someone else this question—what IHS has projected their needs are financially to meet their responsibility versus what either OMB and/or Congress has appropriated?

Dr. DOUGHERTY. Well, at the request of the House Appropriations Committee, the Indian Health Service did a report called "Bridging the Gap" which did project its estimate of what would be needed to reduce the disparity between the U.S. population and Indians. But that report was never issued in final form. It's just available in a draft form.

Senator DECONCINI. When was that report asked for, do you recall?

Dr. DOUGHERTY. I don't know when it was asked for, but the draft is dated June, 1986.

Senator DECONCINI. And do you know why it was never issued? Maybe we'll have to ask somebody else.

Dr. DOUGHERTY. Right, I don't know that.

Senator DECONCINI. You make some comparisons here and statements regarding the urban Indian versus the rural Indian, and the problem of reimbursements, and sliding scale fees, et cetera. Do you have a definite conclusion as to the comparison of the urban versus the reservation Indians as to their life expectancy, or the causes of most of their diseases, or anything like that?

Dr. DOUGHERTY. Well, we couldn't get data on their life expectancy, or on age-adjusted mortality rates. And you do have to adjust for age. But we looked at information on the causes of death, and they're about the same as those——

Senator DECONCINI. Are they?

Dr. DOUGHERTY. Yes, about the same for reservation Indians.

Senator DECONCINI. And what about the availability of care versus the two different classes?

Dr. DOUGHERTY. Well, it's reported to be very low, about half of Indians——

Senator DECONCINI. In the urban areas?

Dr. DOUGHERTY. In the urban areas, yes.

Senator DECONCINI. And do you know, or did you survey, or attempt to find out, how many urban Indians go their separate way for health care, because it's in the community even though they have to pay for it, or that they're covered by insurance, or whatever?

Dr. DOUGHERTY. We couldn't make that determination.

Senator DECONCINI. You couldn't make that determination?

Dr. DOUGHERTY. No. In fact, they have to because only 1 percent of the Indian Health Service budget goes to urban.

Senator DECONCINI. Obviously, the large amount of urban Indians have some other alternative health care, or none.

Dr. DOUGHERTY. Yes, well, the urban projects basically serve as a referral service to try to find other sources of care.

Senator DECONCINI. Thank you.

Does anybody else have any questions?

Senator DASCHLE. Could I just ask one final question?

Senator DECONCINI. Senator Daschle.

Senator DASCHLE. You make reference in your testimony that a lot of the statistical information just wasn't available. We've asked you a lot of questions that, for good reason, you have not been able to answer this morning. From your understanding of the lack of adequate information, do you think the IHS knows the answers to some of these questions?

Dr. DOUGHERTY. Well, as I said, with the administrative personnel, they told me that they wouldn't know the answer without doing a major computer run, and even then it would be hard to tell.

Senator DASCHLE. And the sense I get is that there really has not been a very good examination, statistically or in any other way virtually, by IHS personnel at the highest level with regard to some of the questions we're asking this morning, that they couldn't give us any better information than you could, for whatever reason.

Senator DASCHLE. If that's an erroneous interpretation of some of the things I've heard this morning, I hope you'll clarify it.

Dr. DOUGHERTY. I think that's probably right.

Senator DASCHLE. Thank you.

Senator DECONCINI. Thank you, Senator Daschle.

Dr. Dougherty, thank you very much for your testimony this morning, it's been extremely helpful, and again, my compliments on a very in-depth testimony and statement that you submitted here. It's extremely good.

Dr. DOUGHERTY. Thank you very much.

[Prepared statement and exhibits of Dr. Dougherty appear in the appendix:]

Senator DECONCINI. Our next panel will be composed of Bruce Nicholson, former Indian Health Service physician; John Gobert, a Service Unit Director, Indian Health Service; and Georgia Perez, Community Health Representative. Would you all please step forward and raise your right hands?

[Witnesses sworn.]

Senator DECONCINI. Counselor.

STATEMENT OF BRUCE NICHOLSON, FORMER INDIAN HEALTH SERVICE PHYSICIAN; JOHN GOBERT, COLVILLE SERVICE UNIT DIRECTOR, INDIAN HEALTH SERVICE; AND GEORGIA PEREZ, NAMBE PUEBLO COMMUNITY HEALTH REPRESENTATIVE, INDIAN HEALTH SERVICE

Mr. KLINGENSTEIN. Good morning, Dr. Nicholson, Mr. Gobert, Ms. Perez.

Dr. Nicholson, let me start with you. You've spent some time working as a physician within the Aberdeen Area Office, is that correct?

Dr. NICHOLSON. Yes, it is.

Mr. KLINGENSTEIN. Where are you currently employed?

Dr. NICHOLSON. Currently, I'm residing in Charlottesville, Virginia and practicing emergency medicine.

Mr. KLINGENSTEIN. And where were you within the Aberdeen Area Office?

Dr. NICHOLSON. I spent two years on Pine Ridge Reservation as the Clinical Director for approximately 20 months of my two years.

Mr. KLINGENSTEIN. That was from 1987 to 1989?

Dr. NICHOLSON. Yes.

Mr. KLINGENSTEIN. As the Clinical Director, were you the chief medical officer in that service unit?

Dr. NICHOLSON. Yes, I was.

Mr. KLINGENSTEIN. Dr. Nicholson, we've heard from Dr. Dougherty some pretty grim statistics about Aberdeen Area health. And I'm wondering whether you can comment on the conditions in your service unit, focusing first on the mortality rates and afflictions, and then on any staffing problems that you may have had?

Dr. NICHOLSON. I think initially on the statistics that she presented, they were quite accurate. I think, as she indicated, there's a great deal of disparity from one service unit and one area to another, and when you take the entire Indian Health Service it dilutes out these disparities.

Some instances in our service unit alone, in 1987 we had 26 infant deaths with 500 live births, so that figures out to an infant mortality rate of over 40 per 1,000. There were attempts by our service unit to work and address that, but they were never addressed above and beyond our service unit. Other statistics that I think you see that lead to problems within Indian Health Service with physicians and the delivery of care by nursing staff are, as Ms. Dougherty indicated, high instances of death, premature death I guess is what we would call it, in the age groups of 15 to 20 and 15 to 40, where in one instance we had nine motor vehicle deaths in a period of four months. All of the victims were intoxicated. They were all within the age group of 20 to 40.

Mr. KLINGENSTEIN. Did you also find a high rate of suicide there?

Dr. NICHOLSON. A very high rate. We had a period of six months where we had four deaths by Russian Roulette alone on a reservation of 22,000 persons. And these statistics in themselves, when taken into account, and seeing this day after day, are very difficult to deal with over long periods of time.

Mr. KLINGENSTEIN. So is your experience consistent with the findings reflected on that chart?

Dr. NICHOLSON. I think yes, they are very consistent. There are inordinate numbers of deaths from accidents in adverse conditions. And I think one of the reasons why liver disease and cirrhosis leads is because a lot of the individuals never even make it to that age.

Mr. KLINGENSTEIN. Did you confront staffing problems at the Pine Ridge Service Unit, Doctor?

Dr. NICHOLSON. Yes, considerable staffing problems that went from physicians that were required to see on the average of two or three times as many patients as the average physician—we had 11 clinicians taking care of a total of 22,000 individuals, in a situation where if you were in a small community setting it would be stressful, but not quite as stressful as the Indian Health Service, because of the inordinately high numbers of infectious diseases that you see, alcohol-related problems, and diabetic-related problems. It's put a great stress on a system, and on the physicians and the nursing staff.

The nursing staff was probably about 50 percent of what the Indian Health Service projected we should be at. And I think that probably goes for the rest of our services.

Mr. KLINGENSTEIN. Let me ask you about doctors in particular. Did you have a hard time recruiting and retaining doctors?

Dr. NICHOLSON. We, I don't think, had as difficult time recruiting as we did retaining physicians.

Mr. KLINGENSTEIN. Why was that?

Dr. NICHOLSON. There are a number of dedicated people out there who would be willing to work in Indian Health Service facilities, but they'll come for a couple of years, they stay, they see the conditions, they see that things don't change over two or three years. There seems to be quite a bit of hollow rhetoric once you get above a service unit level in making attempts at changing some of the patterns of the delivery of care, or the allocations of funds to directly impact upon the problems that we see day in and day out as clinicians. And they see this, and then they say, well, you know, I can't do this any more, and they leave after a couple of years.

Senator DECONCINI. Excuse me, Mr. Klingenstein.

You're saying, then, that it is not the monetary remuneration, or lack thereof, that is the primary reason that doctors leave the Indian Health Service?

Dr. NICHOLSON. No, I don't think it is, because as a family clinician if you look at national averages for compensation, Indian Health Service is quite competitive now on a national basis.

Senator DECONCINI. So it's lack of good—I don't want to put words in your mouth—lack of good administration, lack of ability to create morale, and a lack of capabilities to do something positive towards the problem?

Dr. NICHOLSON. Yes.

Senator DECONCINI. Can you elaborate on any of those, or strike any of them, or add anything to that?

Dr. NICHOLSON. It's a lack of responsiveness on the part of Indian Health Service to deal with them. And I think one example is, in reference to the infant mortality rate we experienced in 1987 at

Pine Ridge, the following year we made a request through Indian Health Service at an area level to staff our facility or try to make available funds that would allow us to address this problem through hiring of nurses or individuals that would go out into the communities, community health workers, nurse midwives, and obstetrics people, so that they could address the problem and try to educate the community into the need for the prenatal care. This never came to fruition. We never were able to——

Senator DECONCINI. Was it because of monetary reasons, or more than that?

Dr. NICHOLSON. It was a combination of things. We were told that there was no money, but also that there were no FTEs available for us. In other words, there were no open spaces for people to come into the area.

Senator DECONCINI. And no other explanation of hey, it's a good idea, we're going to work on it. We can't do it this year, maybe next year—nothing to encourage you to stay with the idea?

Dr. NICHOLSON. There was always the, oh the encouragement, yes, it will get done, but it never does.

Senator DECONCINI. Thank you.

Counselor?

Mr. KLINGENSTEIN. You mentioned, Dr. Nicholson, a problem with overload on your doctors. I assume that contributed to burning out of your doctors?

Dr. NICHOLSON. Yes.

Mr. KLINGENSTEIN. Was there also a problem, Dr. Nicholson, in that doctors were asked to do more than they were capable of?

Dr. NICHOLSON. On numerous instances. And I think this is something we addressed quite effectively at Pine Ridge, but it was not addressed, I don't think, as effectively at other service units. And physicians are brought into Indian Health Service, and the mentality is that you're a physician, you've gone to medical school, therefore, you can do anything and everything. And I think anybody who has any knowledge of medical care feels that that's not true, and we see situations where clinicians are expected to do complicated obstetrical care in isolated areas without having the proper tools, equipment, or educational background to deliver that care.

Senator DASCHLE. May I clarify just a couple of points.

You make several references to the infant death rate on the reservation. And I think you said it was 40 per 1,000, Dr. Nicholson. What is the rate in the Country today?

Dr. NICHOLSON. Approximately I think it's between 10 and 11 per 1,000.

Senator DASCHLE. Ten and eleven. So in other words you're talking about a 400 percent increase over what the national rate is for infant mortality on Pine Ridge?

Dr. NICHOLSON. Yes, sir.

Senator DASCHLE. And the Chairman was asking you about what kind of assistance you were being given to try to cope with this in spite of the fact that it's a 400 percent increase. How would you characterize the support you were given by the Aberdeen Area? Did you get the impression they were doing all they could given limited resources? Did you have any concern about the allocation

of resources, even as they came to Aberdeen itself? How would you characterize that kind of support?

Dr. NICHOLSON. I felt in light of what I considered to be a crisis in the delivery of health care, that no, they were not doing all they could. There certainly has to be money out there to address problems at that stage of life, and we were unable to free up any funds whatsoever. They essentially told us there was nothing available for us.

Senator DASCHLE. Let me ask you one other question, much more specifically in this regard. Is it not true that on occasion there were times when money was misallocated, money that was supposed to be spent on health care went to trips that may or may not have been taken, vouchers that were questionably signed, and administrative costs attributed to travel that simply was not spent in the right way?

Dr. NICHOLSON. We addressed that as clinical directors in the Aberdeen area. We were required to spend time traveling on four occasions every year, quarterly, to have two and three day meetings. And a lot of these meetings just ended up in rhetoric on how the service units should work with the Aberdeen Area Office, and finally, on one occasion we voted that we should not have these. That the money should be spent for delivery of direct services.

And I think you see that time and time again, where numerous trips were given to individuals, and monies were allocated for non-direct health care.

Mr. KLINGENSTEIN. Dr. Nicholson, you mentioned that you thought on occasion that doctors were asked to do more than they could do. Do you have a personal experience where you were asked to do something that you weren't qualified to do in your view?

Dr. NICHOLSON. Yes. When I first came to Pine Ridge, I had been practicing emergency medicine for approximately three years, and when I came there my job description entailed that I do routine obstetrical care, which expanded doing prenatal as well as deliveries. And at that point in time I made the comment that I had not done a delivery since medical school, and that I would not do one, because I would not put myself in the situation where I may jeopardize my standard of practice, as well as jeopardize a life of a mother and an infant. And I was told, well, this is the way that Indian Health Service does it.

Fortunately, we had a very understanding service unit director, and we sat down and we were able to work that out. I think, though, that this is not always the case, and that there are numerous rumors, if you might call them, or tales of these types of occurrences that did not turn out so fortunate. Those physicians with very little training were put into those situations and expected to do things above and beyond what their capabilities were.

Senator DECONCINI. Let me interrupt.

Isn't there an ethical question here on the part of physicians to say, "no, I can't do that, supervisor; you know, I'm not trained to do that, and you're asking me to do something that is improper?" Does that come into play?

Dr. NICHOLSON. I think it does. And there certainly is an ethical question, and we were able to address that in our service unit. And because we had enough board specialists, and certified individuals

who felt that ethically they could not do this, that it wouldn't be done. But I think if you get a situation where you're in a small rural hospital, and there's no one else to do it——

Senator DECONCINI. Yes, so it's either wing it a little bit, or it doesn't happen, right?

Dr. NICHOLSON. Yes.

Senator DECONCINI. Thank you.

Mr. KLINGENSTEIN. Dr. Nicholson, as clinical director, did you ever experience any problems with the quality of care that was provided by other doctors?

Dr. NICHOLSON. Yes. I think, no more so than what you might see in the private sector, but we routinely screened and looked at our physicians in their delivery of care, and when problems did arise, we made an attempt to address those.

Mr. KLINGENSTEIN. Do you have any experience where a doctor did perform badly, and it was difficult to remove him from the unit?

Dr. NICHOLSON. Yes, we had one instance while I was there that I initiated a quality assurance review process, which entailed review of a clinician's privileges due to the fact that he had had several—what we would consider several untoward outcomes where patients had died or there was very questionable delivery of care. After careful review by the medical staff it was felt that there was very strong evidence that this clinician was practicing substandard care. We went to an Area level and requested further assistance, and essentially were stymied at that point.

Mr. KLINGENSTEIN. Can you just briefly describe the examples of the poor care?

Dr. NICHOLSON. A couple of examples that come to mind is this clinician saw a patient at 2:00 o'clock in the afternoon that had a history of renal insufficiency, and his wife had indicated that he was having troubles breathing and had gained significant weight over a period of about a month. The clinician sent him home saying that he was fine. He came back in eight hours later in severe congestive heart failure and died before we were able to get him out and to treat him. This was a 42-year-old gentleman, who for all rights should still be alive today.

This same clinician was involved with a case with a woman who was brought in with a heart attack, and the nurse called him indicating that the patient was having problems breathing. He told the nurse to give the patient a breathing treatment, and 45 minutes later the patient arrested in the hospital, and was unable to be resuscitated.

Mr. KLINGENSTEIN. Is that particular doctor still with IHS?

Dr. NICHOLSON. He is currently still with IHS.

Mr. KLINGENSTEIN. Is he about to be removed?

Dr. NICHOLSON. He's about to be released. He had an obligation through his scholarship, and finally the service unit director gave an ultimatum that this clinician would no longer see patients, that he would be strictly administrative for his remainder of time in Indian Health Service.

Mr. KLINGENSTEIN. How long did it take from the original identification of a problem until his proposed termination?

Dr. NICHOLSON. Approximately 16 months.

Mr. KLINGENSTEIN. Dr. Nicholson, do you have any experience with part-time doctors?

Dr. NICHOLSON. Yes. We, on occasions, would use the referral service that Indian Health Service had given us access to for bringing physicians in.

Mr. KLINGENSTEIN. What was your experience with that service?

Dr. NICHOLSON. It was marginal at best. The quality of the clinicians that they referred to us—we would give them data as to what type of clinician we would want, say for instance a general practice physician who was able to do obstetrical care, and they would refer us a 72 or 75-year-old retired neurologist and say, well, this is what we got for you to do general medical care.

And we had one instance where they sent us an obstetrician who had presented himself as a competent general clinician and on review of his charts after being there only a couple of weeks, realized that this clinician was unable to even interpret a basic electrocardiogram. And from that time on we limited his privileges to strictly obstetrics. But, you know, we had some difficulties with them.

Mr. KLINGENSTEIN. Dr. Nicholson, I wonder if you could give the committee any recommendations as to how you believe the problems we've identified could be addressed?

Dr. NICHOLSON. It's difficult in a short time to address how we could remedy some of these, but I think as a clinician one of the most important things would be for Indian Health Service to get back to the basics and start to discuss at a community level what needs to be done and truly look at the statistics as Ms. Dougherty presented them, rather than what Indian Health Service presents as their skewed statistics on improved health care in the American Indian.

Number two, addresses the disparity of physicians between one area and another, especially as Senator Daschle is well aware of our shortage in the Aberdeen area. The goal of Indian Health Service is to distribute their clinicians throughout Indian Health Service to effectively meet the needs of certain areas. That was brought to the attention of, I think, a committee awhile back when they questioned the need for a commission corps. And the defense of Indian Health Service was that a commission corps was a mobile force that was able to be distributed throughout the most needed areas. In Pine Ridge we spent a year trying to get them reallocate, or relocate a commission corps officer to our facility, and we were told that there were none available. So I would say, do away with the commission corps, because it never meets the needs.

Mr. KLINGENSTEIN. Thank you very much, Dr. Nicholson.

Mr. Gobert, let me ask you a few questions that are raised by Dr. Nicholson's testimony. You are currently a service unit director, is that correct?

Mr. GOBERT. Yes, sir.

Mr. KLINGENSTEIN. And that's at Colville Service Unit in Washington?

Mr. GOBERT. Yes, sir.

Mr. KLINGENSTEIN. Now, you've spent some time in the past at the Rosebud and Pine Ridge Service Units, is that right?

Mr. GOBERT. Yes, sir. I spent a total of about 10 years in the Aberdeen area as a service unit director.

Mr. KLINGENSTEIN. And as part of your duties as service unit director, were you also responsible for recruiting doctors, sir?

Mr. GOBERT. Yes, sir.

Mr. KLINGENSTEIN. Do you find similar problems as confronted by Dr. Nicholson?

Mr. GOBERT. We've had numerous problems with Project USA, at both of the locations I have been with.

During the time I was at Rosebud, we had probably in excess of 50 temporary physicians who rotated through there on a yearly basis.

Mr. KLINGENSTEIN. What is Project USA, sir?

Mr. GOBERT. That is an organization of the American Medical Association, and the Indian Health Service contracts for so many weeks of coverage from that organization to be distributed to the service units to cover those periods of time when your permanent docs are on vacation, continuing medical education leave, those type things.

Mr. KLINGENSTEIN. So it's a referral service that provides part-time doctors, is that right?

Mr. GOBERT. Yes, sir.

Mr. KLINGENSTEIN. Is it also known by the name of Rent-a-Doc?

Mr. GOBERT. Yes.

Mr. KLINGENSTEIN. Did you have specific experiences with particular doctors that were provided by this service, sir?

Mr. GOBERT. Yes.

Mr. KLINGENSTEIN. Can you describe a couple of them?

Mr. GOBERT. The first one was a physician that was referred to us that came to us utilizing false credentials. And what that meant is he had found out—his license was suspended, and he was not able to practice, and he found out from another physician who he had apparently known, and he took his provider number and based upon that erroneous information he was sent out to the service units to practice medicine.

Mr. KLINGENSTEIN. So he represented himself as a licensed physician, when he was not?

Mr. GOBERT. That's right, sir.

We did some more background checks on him, internally, and we found out that his license was indeed suspended and we would not let him practice, and we sent him out of there.

Mr. KLINGENSTEIN. And did you have another experience, sir, with a physician who was patently incompetent?

Mr. GOBERT. Yes, sir. We have another physician who was referred to us from Florida, and he became known as the belly button doctor, and his method of treatment was to take a cotton ball, dip it in mineral oil, and tape it into the navel.

Mr. KLINGENSTEIN. Did that prove to be an effective means of treatment, sir?

Mr. GOBERT. No, sir. We had one patient who presented himself to the individual with a bleeding ulcer and after this was again brought to our attention, we immediately got him out of there.

Mr. KLINGENSTEIN. Now these two——

Senator DASCHLE. Can I just interrupt?

Do you mean to say that that was his remedy? The medical care he was providing was that somebody would come in with an ulcer or some difficulty and his only response was to tape some oil-soaked cotton ball to the belly button?

Mr. GOBERT. That is true, Senator Daschle.

Senator DASCHLE. How long a period of time did this occur?

Mr. GOBERT. Well, as I said, we went through a period in excess of 50 of these temporary physicians at Rosebud in that particular year that I was there. And it was our feeling that adequate background checks were not done on these individuals, that we would get them out there, and really have to keep a close eye on them to make sure that these types of things did not happen. Once they did happen, they were sent out.

Senator DASCHLE. But in his case, Mr. Gobert, how long from the time he arrived to the time that practice was exposed was he allowed to practice? And approximately how many patients, during that time, given your experience, may he have treated?

Mr. GOBERT. I would say anywhere from two to three days, Senator Daschle. The amount of patients, I couldn't answer that.

Mr. KLINGENSTEIN. Do you know whether that doctor, the belly button packer, is still practicing medicine?

Mr. GOBERT. That I do not know. That's up to the State of Florida if they give him those privileges.

Mr. KLINGENSTEIN. Now, these instances occurred in the early 1980s, did they not, when you were at Rosebud?

Mr. GOBERT. Yes, sir.

Mr. KLINGENSTEIN. Now, have you had a similar experience with Project USA currently at Colville?

Mr. GOBERT. Yes. We operate another facility where we utilize the Project USA physicians, and the time I've been there from August to the present, we've had about two of the eight Project USA physicians that were unacceptable to us that were sent back.

Senator DECONCINI. Did you ask him, where do the USA physicians come from? Do you know how it's put together?

Mr. GOBERT. It's a contract, sir, that the Indian Health Service enters into with the American Medical Association, and it's administered out of Chicago by a gentleman by the name of Mr. John Naughton, that is Project USA. That is the name for it.

Senator DECONCINI. And USA, or Mr. Naughton, in essence, picks the ones, or finds the ones that are willing to come on board and go to work for IHS, is that how it works?

Mr. GOBERT. Yes, sir.

Senator DASCHLE. I get the impression that your experience thus far would lead one to conclude that IHS is a virtual dumping ground for inefficient doctors that can't make it in private practice. Is that too harsh a characterization?

Mr. GOBERT. The majority of the physicians that they get are elderly, that they have been semi-retired, some of them may have been very good in their own specialty, but to address the needs that we need as far as being able to work the hospital, take care of the general population that comes in with a variety of illnesses, those type things, and then participate in the call schedule, and those things are just not adequate.

Mr. KLINGENSTEIN. Thank you, Mr. Gobert.

Ms. Perez, let me just ask you a couple of questions.

Ms. PEREZ. Okay.

Mr. KLINGENSTEIN. You are Georgia Perez?

Ms. PEREZ. Yes, I am.

Mr. KLINGENSTEIN. And you are currently a community health representative, is that right?

Ms. PEREZ. Yes, I am.

Mr. KLINGENSTEIN. What is a community health representative?

Ms. PEREZ. A community health representative is a liaison person from the tribe who works in the community providing various types of health activities in the community. And we also serve as liaison person to Indian Health Service for our clients.

Mr. KLINGENSTEIN. You sort of act as the front line of defense and have the most immediate contact with the tribal members?

Ms. PEREZ. Yes. CHR, I'm more used to being called that, is the person that we have the first contact with the patient out in the field. We will walk into a home and we will find a problem that needs medical attention, so we will refer this patient to the proper physician, or service that's needed.

Mr. KLINGENSTEIN. I just wonder if you could comment on some of the points made by the other panelists, starting first with the question of staffing. Do you feel, in your area, that there's adequate staffing there?

Ms. PEREZ. Right now, because of present budget deficits we are going through a very—we're starting to be cut down in staffing. For instance, our public health nurse who comes out, we have had one at our Pueblo, plus three others Pueblos. And she was stationed out there one day a week for Nambe Pueblo. And she left to go to another area, so we have been told that this position will be frozen and will not be filled because of a deficit that they have in the public health nursing line budget.

Mr. KLINGENSTEIN. You operate in the Nambe Pueblo, New Mexico?

Ms. PEREZ. Nambe Pueblo, New Mexico.

Mr. KLINGENSTEIN. And that's within the Albuquerque Area Office, is that right?

Ms. PEREZ. Yes, yes it is.

Mr. KLINGENSTEIN. Let me ask you whether you believe, as others have stated, that there are immediate procedures that are being deferred, not being given to the Indian population?

Ms. PEREZ. I think there are, but I think Santa Fe Service Unit does—they do a good job of providing the services for the Indian people, because our facility does have more specialty care areas than other areas out of Albuquerque. We do have a surgeon on board, we do provide the surgeries, the specialty care for obstetrics, where other areas are having to be referred to Santa Fe.

Mr. KLINGENSTEIN. Thank you very much, Ms. Perez.

That's all I have for this panel.

Senator DECONCINI. Senator McCain, do you have any questions of the witnesses?

Senator MCCAIN. Do you feel that the community health representative is a crucial link in the health care we provide for Native Americans?

Ms. PEREZ. Oh, yes, I do. If I didn't I wouldn't have been there for—I've been there 13 years now.

Senator MCCAIN. And you're aware that at various times in the past few years funding for your work has been recommended to be eliminated?

Ms. PEREZ. I'm well aware of it.

Senator MCCAIN. And what has been the reaction to that amongst your clients?

Ms. PEREZ. It's very upsetting, not only to the persons who are working in the field, but to the clients, especially for our elderly. We're the contact people for them in the community. They may not see anybody else for a whole week, but the CHR at least goes to that home and walks in and makes sure that that client is okay, and isn't in need of any kind of care.

Indian Health Service doesn't come out to the patient's door. We're there.

Senator MCCAIN. From my experience, it also appears to me those numbers would be considerably higher if it were not for the work that you do in preventative medicine.

Ms. PEREZ. I think so.

Senator MCCAIN. Thank you, Mr. Chairman.

Senator DECONCINI. Senator Daschle?

Senator DASCHLE. Thank you, Mr. Chairman.

What is the—John or Bruce, or anybody, could you just give as succinct an answer as you can in this regard, but what is the perception of the IHS by Indian people themselves who receive this care?

Bruce?

Dr. NICHOLSON. I think it's somewhat skeptical at times. It has changed, fortunately, in some areas. There are still patients who come in and they question what type of care they're getting, and whether or not we're experimenting on them as clinicians. But I think the quality overall—and I'd like to emphasize that the clinicians that work now in Indian Health Service for the most part are extremely dedicated, highly qualified. There are some problems with a few clinicians within the Service and certainly with Project USA, the clinicians that are delivered from them, but the people, I think, feel somewhat comfortable with the care that's delivered. They certainly feel, as we saw it numerous times at Pine Ridge, that it's inadequate and that their needs are not being met to the fullest extent, or even near that level.

Senator DASCHLE. And I look at these death rates, four times, three times the rate of the American people and if I were somebody living on a reservation I guess I'd be just appalled. I'd be outraged by it. It would seem to me that it would probably be of all things, the most important goal to try to alleviate that and demand that those of us in the Congressional delegations that something be done. But I don't sense that, and I'm trying to decide why it is. Can anybody enlighten us?

Dr. NICHOLSON. I guess from my experience, it goes back to what I discussed earlier. The fact that quite often when we bring forth the problems, they are—we're told, or we were told that, you know, this is not something that needs to be discussed. And one good example is, we had a director for our community health program that

was very effective at making great inroads on the Pine Ridge Reservation. About a year and half ago he wrote a letter indicating his discontentment with the significant cutbacks at the area level toward our community health program, and it was made very clear to him that this type of activity was not considered appropriate for a commissioned officer, and because of his discontentment, he subsequently left out of fear that the retribution would be there, that as a commissioned officer he would be stifled and never again get another promotion. So he left Indian Health Service.

Senator DASCHLE. John, were you contacted at all by Rockville, or by the national office in regard to your testimony this morning?

Mr. GOBERT. No, sir. There was a message that was relayed through my immediate superior, Dr. Batliner, to cooperate with the committee..

Senator DASCHLE. Cooperate?

Mr. GOBERT. Yes, sir.

Senator DASCHLE. With regard to the management as you saw it in the Aberdeen area, did you sense that if you brought out difficulties that someone was going to respond to them, or were you frustrated in your inability to present problems to management and have them addressed properly, John?

Mr. GOBERT. It was my feeling that when we did not agree with management, when we wanted to possibly redirect resources, we were looked upon as troublemakers down there at Pine Ridge. And as Dr. Nicholson has pointed out, I think that the money is there, the position is there, but the people in the echelon above us have their own criteria, as far as how they want to see these funds spent, and how they want to allocate these positions and those type things, and it needs to get back to the basics again of the service unit people, that's where everything takes place, and we need to be involved in that aspect of the management, and they need to start listening to us, because we are the ones that are going to make the direct impact down there, not the people sitting in the area office, but the people that are at the service unit level.

Senator DASCHLE. Let me just ask you one last question. During my visits to Pine Ridge, I've been made aware that there are certain times of the month when the level of care is far more significant, the number of patients coming in are more significant than other times of the month. Is that a correct perception?

Dr. NICHOLSON. Yes, it is.

Senator DASCHLE. And why is that a fact?

Dr. NICHOLSON. Quite often it deals with—it has to do with the cycles of the government checks that come out. And we see a very high incidence within 1 week or 2 weeks after government checks come out, or BIA moneys, with alcohol-related problems, deaths, beatings, violent types of situations at significant elevations.

Senator DASCHLE. When you say significant, how many more times than the regular monthly average might that be?

Dr. NICHOLSON. I think it would be difficult to quantitate that, but I would say if you looked at patterns, we certainly did have rises maybe two or three times the amount.

Senator DASCHLE. Two to three times?

Dr. NICHOLSON. Yes.

Senator DASCHLE. So on a peak evening how many specific patient cases may require care on the part of one doctor?

Dr. NICHOLSON. I can recall for myself that on a Friday night after checks came out I spent from midnight until 6:00 o'clock in the morning suturing up 13 individuals that had been involved in violent altercations.

Senator DASCHLE. Thirteen in one night?

Dr. NICHOLSON. Yes.

Senator DASCHLE. Did they all survive?

Dr. NICHOLSON. They all survived that night.

Senator DASCHLE. In making that fact known, that there are certain times of the month when care is all the more critical, has any thought ever been given to augmenting the hea. h service at least during those critical periods when the patient load number is far in excess of what might otherwise be the case?

Dr. NICHOLSON. I don't think—we, of course, as clinicians at the service unit level would like to have seen that, but there was no room for that above and beyond our level to consider that, I don't think.

Senator DASCHLE. Do you care to comment on that, John?

Mr. GOBERT. We did look at that situation, Senator Daschle, and in talking with the physicians it was becoming increasingly difficult to ask them to work a regular tour of duty, and then come in and work all night, and then come back the next day and see those patients, and we did put together a proposal to contract, much like they do in the civilian sector, for emergency room physicians to come out and cover so our docs could have some rest during that period of time, but unfortunately it wasn't funded.

Senator DASCHLE. It was once described to me that a situation as you've just described it, Bruce, it was described to me by a doctor who had served a couple of terms in Vietnam, that it was very similar to a hospital in Vietnam with all of the incredible—the emergency situations as they saw it. He said he had never seen anything like it.

Are you able to provide—I mean, 13 specific emergency cases from midnight to 6:00 in the morning, how in the world can you provide any kind of adequate care? I guess, I'm asking, under those circumstances, how is it possible that anybody stays on? The impression I have is that burnout would be so dramatic, that after a while patients cease to become even human beings, that care would really become so routine that you couldn't keep the edge and the sensitivity you have to as a physician.

Dr. NICHOLSON. Yes. That sort of hits home personally, I guess. I've practiced emergency medicine now for five years, and have practiced in numerous different settings, and I must honestly say I did make that comment to my wife the other day, that it's taken me about three months to start to regain my sensitivity again. Because in all honesty, that's truly what happens after a while. You become quite indifferent to the situations that you see day in and day out. And it's certainly not fair to us as clinicians, and it certainly is not fair to the patients that we serve.

Senator DASCHLE. Thank you, Panel. Thank you, Mr. Chairman.

Senator DECONCINI. I want to thank you as witnesses for the statements that you've also submitted, which will appear in the

record in full. They are very, very helpful and your testimony has been extremely enlightening today. Thank you very much.

[Prepared statements of Dr. Nicholson, Mr. Gobert, and Ms. Perez, and the Exhibits of Ms. Perez appear in appendix.]

Senator DECONCINI. Our next and last witness this morning will be Larry Morey, Assistant Inspector General, Investigations Division, Office of the Inspector General, Department of Health and Human Services.

Mr. Morey, would you please come forward and raise your right hand?

[Witness sworn.]

Senator DECONCINI. Mr. Klingenstein, go ahead.

STATEMENT OF LARRY D. MOREY, ASSISTANT INSPECTOR GENERAL, INVESTIGATIONS DIVISION, OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. KLINGENSTEIN. Good morning, Mr. Morey.

Mr. MOREY. Good morning.

Mr. KLINGENSTEIN. Mr. Morey, you are the Assistant Inspector General for the Department of Health and Human Services, is that right?

Mr. MOREY. That's correct.

Mr. KLINGENSTEIN. And that's known as the IG's Office?

Mr. MOREY. Yes.

Mr. KLINGENSTEIN. Sir, how long have you been with the Inspector General's Office?

Mr. MOREY. I've been with the Inspector General's Office for eight years.

Mr. KLINGENSTEIN. And what did you do prior to coming to the IG's Office?

Mr. MOREY. Prior to that I was a special agent with the Federal Bureau of Investigations for 13 years.

Mr. KLINGENSTEIN. So you were an FBI agent for 13 years, and have a total of over 20 years of investigative experience in the area of criminal investigations, is that right, sir?

Mr. MOREY. Yes, it is.

Mr. KLINGENSTEIN. Mr. Morey, could you describe your current duties at the IG's Office?

Mr. MOREY. Yes. As the Assistant Inspector General for Investigations I have the responsibility of conducting, overseeing and coordinating all the investigations in the Department relating to fraud, waste and abuse.

Mr. KLINGENSTEIN. So it's your office within the IG that is charged with pursuing allegations of a criminal nature that involve the IHS and other agencies within HHS, is that right?

Mr. MOREY. Yes, it is.

Mr. KLINGENSTEIN. Sir, what are most of the sources of your investigation?

Mr. MOREY. Probably the biggest source of the complaints come in from the components themselves. And they may be a Social Security violation, a health care violation from HCFA, or they'll come in from the Indian Health Service.

Mr. KLINGENSTEIN. Now, sir, did your office conduct an investigation of the Bemidji Area Office?

Mr. MOREY. Yes, we did.

Mr. KLINGENSTEIN. That's an area office within IHS, is that correct?

Mr. MOREY. Yes, it is.

Mr. KLINGENSTEIN. Are you familiar with the facts of this investigation, sir?

Mr. MOREY. Yes, I am.

Mr. KLINGENSTEIN. And you oversaw the running of that investigation, is that right, sir?

Mr. MOREY. Particularly I'm aware of this one because it involved a member of the Senior Executive Service, and I was updated on a weekly basis.

Mr. KLINGENSTEIN. Now, was the investigation started in approximately the summer of 1988, sir?

Mr. MOREY. That's correct.

Mr. KLINGENSTEIN. And was it handled by your Minneapolis Office?

Mr. MOREY. Yes, it was.

Mr. KLINGENSTEIN. Was Karen Sweet the agent in charge of the case, sir?

Mr. MOREY. Yes, she's currently the agent handling that case.

Mr. KLINGENSTEIN. And it's an ongoing case?

Mr. MOREY. Yes, it is.

Mr. KLINGENSTEIN. Sir, did your office find evidence of travel voucher fraud, fiscal mismanagement, excessive and improper expenditures on conferences and various personnel abuses?

Mr. MOREY. Yes, we did.

Mr. KLINGENSTEIN. That was in connection with your Bemidji investigation?

Mr. MOREY. That's right.

Mr. KLINGENSTEIN. Did the investigation reveal systematic abuses in the travel voucher system, sir?

Mr. MOREY. Yes, it did.

Mr. KLINGENSTEIN. Were various IHS employees found to have been approving each other's travel vouchers in violation of specific regulations, sir?

Mr. MOREY. Yes.

Mr. KLINGENSTEIN. And is it correct, sir, that the investigation, while originally focused on one individual expanded to focus on several?

Mr. MOREY. Originally the allegation was on one individual, and to date we have five.

Mr. KLINGENSTEIN. That individual was Alan J. Allery, sir?

Mr. MOREY. That's correct.

Mr. KLINGENSTEIN. Who is he?

Mr. MOREY. He's the area director for the Bemidji Office.

Mr. KLINGENSTEIN. Is he currently the area director?

Mr. MOREY. No, he's not. He subsequently resigned.

Mr. KLINGENSTEIN. And has Mr. Allery been indicted on three felony counts of submitting fraudulent travel vouchers by a Federal Grand Jury, sir?

Mr. MOREY. That's correct.

Mr. KLINGENSTEIN. And that indictment was made on the basis of your investigation, sir?

Mr. MOREY. Yes, it was.

Mr. KLINGENSTEIN. Has Mr. Allery come to trial?

Mr. MOREY. That case is not before a jury at this time.

Mr. KLINGENSTEIN. And has the investigation, sir, led to the conviction of two other employees for the submission of fraudulent travel vouchers?

Mr. MOREY. Yes, it has.

Mr. KLINGENSTEIN. Did your office also determine, sir, that travel doubled from the years 1983 to 1987 where expenditures went from $440,000 to $924,000, almost a million dollars in the span of four years, sir?

Mr. MOREY. That's correct.

Mr. KLINGENSTEIN. And did the investigation into these travel abuses reach into the Aberdeen Area Office as another area office who was involved in processing travel vouchers, sir?

Mr. MOREY. We found the internal controls weak in both the Bemidji and in the Aberdeen Office.

Mr. KLINGENSTEIN. And in addition, sir, in the procurement area did your office find that the Bemidji Area Office manipulated the procurement system to pay for unauthorized items by creating blanket purchase orders with various tribes, sir?

Mr. MOREY. Yes, we did.

Mr. KLINGENSTEIN. And did your office determine that health care funds were used to finance extravagant meetings held by area and associate directors which meet regularly during the year, is that correct, sir?

Mr. MOREY. Yes, it is.

Mr. KLINGENSTEIN. These are the area directors of the various IHS area offices, and top headquarters personnel, is that right, sir?

Mr. MOREY. Yes, it is.

Mr. KLINGENSTEIN. Now, did your office issue a report on the basis of its investigation, sir?

Mr. MOREY. Yes, we did.

Mr. KLINGENSTEIN. And did the report disclose that at least once a year these meetings were held at expensive resort locations such as Mackinaw Island, Michigan, Bar Harbor, Maine, and Miami Beach, Florida?

Mr. MOREY. Yes, it did.

Mr. KLINGENSTEIN. Did you find that the Michigan trip, in particular, cost almost $6,000 in excess of the per diem paid to its 26 participants?

Mr. MOREY. Yes, that's right.

Mr. KLINGENSTEIN. Sir, I would like to read from the report issued by your office. In the budget area the report read "the IHS budget is currently structured in such a way that it is almost impossible to determine administrative costs." Do you recognize that, sir?

Mr. MOREY. Yes, I do.

Mr. KLINGENSTEIN. In the area of conferences it noted and recommended "that more emphasis be placed on providing health care for Native Americans instead of on elaborate conferences." Do you recognize that?

Mr. MOREY. Yes, I do.

Mr. KLINGENSTEIN. And did it also state, sir, "that providing the quantity and quality health care for indigent American Indian citizens is too vital for IHS to continue tolerating the waste of program funds and abuse of personnel."

Mr. MOREY. Yes, I recognize that.

Mr. KLINGENSTEIN. Now, did your report make various recommendations for correcting the widespread abuses in the area of travel voucher fraud, personnel and procurement, sir?

Mr. MOREY. Yes. We made recommendations.

Mr. KLINGENSTEIN. The original report from which I'm quoting, is a management implication report, sir?

Mr. MOREY. The original one from the agent is the MIR.

Mr. KLINGENSTEIN. What is that?

Mr. MOREY. That's the management implication report. There's a recommendation from our case agent on how to plug up loopholes in our system.

Mr. KLINGENSTEIN. And was that report then summarized into another report that was sent to HHS?

Mr. MOREY. Yes, after that MIR comes into our office, we analyze it and then it leaves the Office of the Inspector General to other components. In this case to PHS, it goes out as a management advisory report.

Mr. KLINGENSTEIN. And that included various recommendations for correction?

Mr. MOREY. Yes, it does.

Mr. KLINGENSTEIN. Has your office received a response from the Department on your report, sir?

Mr. MOREY. We received a draft response last Friday.

Mr. KLINGENSTEIN. Do you consider that response to be adequate, sir?

Mr. MOREY. In my opinion, it could be substantially stronger. I thought that the PHS did not recognize all the pitfalls that we had indicated. They certainly cite their internal control policies and procedures, but I felt that they did not acknowledge, to my satisfaction, that they had problems in IHS, and did not give enough consideration on what will eliminate the problems in the future.

Mr. KLINGENSTEIN. Well, let me ask you, sir, whether your office is also currently investigating top management personnel in the Albuquerque Area Office, is that correct, sir?

Mr. MOREY. Yes, it is.

Mr. KLINGENSTEIN. Is that in connection with investigations surrounding use of funds intended for alcohol abuse prevention, which went instead for a $70,000 retreat for top IHS executives, is that correct?

Mr. MOREY. That allegation has recently arrived, and basically that is correct.

Mr. KLINGENSTEIN. And it's being pursued?

Mr. MOREY. Yes, it is.

Mr. KLINGENSTEIN. So it's an ongoing case?

Mr. MOREY. It just arrived and yesterday we did open a case.

Senator DASCHLE. I just would like to clarify this. I was, along with several others, involved with the program, this alcoholism program. The funds, of course, are extraordinarily limited current-

ly for the adequate implementation of this program. They've told us on numerous occasions that if we only had additional funding for that particular program, we could be doing a number of things authorized in that legislation that have never been carried out. What you've just said is that $70,000 of this money was used for a retreat?

Mr. MOREY. Are we talking about Albuquerque, Senator?

Senator DASCHLE. That's correct.

Mr. MOREY. That is such a recent investigation, I would be hard put to testify to it.

Senator DASCHLE. You don't know the specifics?

Mr. MOREY. No; I do not. I can certainly provide those for the record at a later date. That is a recent complaint in our office. It's still in our headquarters and has not even been referred to our regions.

Senator DASCHLE. Is it analogous to any other circumstances throughout your investigation that have been found?

Mr. MOREY. Well, as I reviewed it and as I have also analyzed our Bemidji and other cases, I think that they have a lot of similarity.

Senator DASCHLE. In other words, this isn't the first time that funds have been taken from health programs for purposes of retreats, or some kind of a meeting?

Mr. MOREY. No; that would not be the first time.

Mr. BALLEN. Senator, perhaps I can shed some light. It's difficult for Mr. Morey to respond on an ongoing investigation, but this is an area that the committee is looking into, this Sunrise Spring Resort, where over $70,000 was taken, as best we can determine to date, and we're still investigating it, from the alcoholism funds so that the participants could receive massage therapy and various other benefits at a 5-day resort and retreat, outside of Santa Fe.

Senator DASCHLE. This is a 5-day resort. Who was it designated for?

Mr. BALLEN. Well, my understanding is that it was designated for IHS top level officials. Primarily those were those in attendance. It was originally billed to include tribal people, but they never seemed to make it there.

Senator DASCHLE. It was for tribal people, how many tribal people actually were there, do we know?

Mr. BALLEN. I believe two.

Senator DASCHLE. There were two tribal people?

Mr. BALLEN. That's right.

Senator DASCHLE. And we spent $70,000 on two tribal people?

Mr. BALLEN. That's correct. And I may want to point out for the record, that illegal procurement practices—the Federal procurement regulations were not followed. The Contracting Officer himself stated that he would have never have approved such a gambit. And what happened was they used a memorandum of agreement where they signed with an organization, the head of which had been detailed from IHS, in order to get these funds approved, because the Contracting Officer wouldn't approve it. That's what he's told us.

Senator DASCHLE. That's just outrageous. That is outrageous. And this apparently is not the first time.

Do we know, at this point, whether or not that would be an illegal misallocation of funds?

Mr. MOREY. I would suggest it would be, Senator.

Senator DASCHLE. And your investigation at this point is where? How far along in the investigation are you?

Mr. MOREY. Again, we're talking about Albuquerque?

Senator DASCHLE. Albuquerque.

Mr. MOREY. I'd say it's at the beginning stages.

Senator DASCHLE. At the beginning stages. So it's far too early, to determine whether indictments may be forthcoming?

Mr. MOREY. Well, it absolutely is too early, but we will certainly pursue it based on the allegations that we've received.

Senator DASCHLE. I would certainly hope so.

Mr. KLINGENSTEIN. Finally, Mr. Morey, I want to ask you whether your office's audit division has an ongoing case into the Oklahoma Area Office?

Mr. MOREY. Yes, it does.

Mr. KLINGENSTEIN. And in that case is IG looking into allegations that certain procurement——

Mr. BALLEN. Where is this, Mr. Klingenstein?

Mr. KLINGENSTEIN. This is in Oklahoma, Oklahoma City Area Office.

Your office is looking into allegations that some procurement regulations are being circumvented to create a large cash pool which may not have been properly spent, are those among the items being investigated, sir?

Mr. MOREY. Yes; it's the Office of Audit within the OIG that's conducting that.

Mr. KLINGENSTEIN. That's not your office. It's another office within IG, is that right?

Mr. MOREY. That's correct.

Mr. KLINGENSTEIN. Do you know where that investigation stands, sir?

Mr. MOREY. Well, it's more formally an audit.

Mr. KLINGENSTEIN. Excuse me.

Mr. MOREY. The current status of that audit is two-fold. First, we, the Inspector General's Office of Audit have two audits going. In 1984 we made numerous recommendations that they're currently trying to determine whether or not have been implemented, and if not, why not. A second audit is underway to address the area that you just explained, that there were numerous outstanding contracts that had never closed. We currently have an IHS task force there that will attempt to close those contracts, and after they have closed those contracts our auditors will determine whether or not there's been any misappropriation of the funds.

Mr. KLINGENSTEIN. Are part of the allegations that if the contracts have not been closed for many years, it's difficult to account for the way the contract funds were spent, sir?

Mr. MOREY. That's absolutely true.

Mr. KLINGENSTEIN. Okay.

So, sir, you have outlined for this committee, either investigations or audits at the Albuquerque, Bemidji, Oklahoma and Aberdeen Area Office to the extent the Aberdeen Area Office was connected with the Bemidji investigation, is that right, sir?

Mr. MOREY. That's right.

Mr. KLINGENSTEIN. Thank you very much.

That concludes my questioning, Senator.

Senator DECONCINI. Senator Daschle, do you have any questions?

Senator DASCHLE. Just for clarification purposes, Mr. Morey, do you feel that the travel voucher fraud that you found in Bemidji would extend to the Aberdeen Area as well?

Mr. MOREY. Well, I certainly know some of the internal control functions in the Aberdeen Office were not in effect, or else the misappropriation of the funds could not have occurred in Bemidji. I think the answer to your question has to be yes.

Senator DASCHLE. Just sort of an overall question, and my only other real question is, do you feel that the problems uncovered by your investigation suggest serious problems within IHS, or are these isolated cases?

Mr. MOREY. No; I think they're serious, Senator, and I don't think they're isolated at this time.

Senator DASCHLE. In other words, you view this as symptomatic of the whole accounting structure within IHS?

Mr. MOREY. Well, when I received the first allegation, the answer would have been no, but after we've uncovered five employees in the Bemidji area and after these other investigations, the answer at this point would be yes.

Senator DASCHLE. If I can characterize what you've told this committee, is that fraud and gross abuse of the current accounting system is pervasive within the system today?

Mr. MOREY. I think that's a fair statement, yes.

Senator DASCHLE. Thank you.

Senator DECONCINI. Mr. Morey, in the course of the Inspector General investigations, and I used to know the answer to this, and it has slipped my mind, do you make any recommendations for corrective measures?

Mr. MOREY. Yes; we do, Senator.

Senator DECONCINI. You do. And the investigations that you're conducting now, the one in New Mexico, and what have you, they will also have recommendations of some nature?

Mr. MOREY. Yes; they will.

And in fact, if I can expound on that, we're certainly interested in the criminal justice system, but for my agents to report how a fraud was perpetrated, and for us to take the corrective actions through this MIR and MAR process, is more important to us.

Senator DECONCINI. Thank you. I have no further questions.

Mr. Ballen.

Mr. BALLEN. Just for the record, Mr. Morey, on the Bemidji Office you said there were recommendations made. Have those recommendations been adopted by the IHS, or not?

Mr. MOREY. I only hesitate because I'm working off a draft communication from Public Health Service, and they certainly can change their response after this hearing. I would suggest a lot of things they did address, and they certainly have the policies and procedures that have already been written that would probably have stopped this fraud from being perpetrated, if they had been followed.

My concerns would be that there is some way that they could implement their current policies and procedures and that there would be some awareness on the part of the employees that they could bring that to the attention of the Inspector General's Office if that occurred. And that would be what I would be looking for in a response, some reassurance that in the future their employees will have fraud awareness training and that things like this will not reoccur.

Mr. BALLEN. And that assurance you haven't gotten at this point in time?

Mr. MOREY. I don't feel I've had that assurance.

Mr. BALLEN. Thank you, sir.

Senator DECONCINI. Thank you, Mr. Morey, very much for your testimony. It's very helpful to us.

The committee, as stated at the beginning of our hearing this morning, will not meet this afternoon. Our next committee meeting will be tomorrow morning at 10:00 a.m. in this room. We'll stand in recess until then.

[Whereupon, at 12:10 p.m., the Special Committee on Investigations was recessed, to reconvene at 10 a.m. on Tuesday, May 16, 1989.]

APPENDIX

Additional Material Submitted for the Record

STATEMENT BY CHAIRMAN DECONCINI

ON THE INDIAN HEALTH SERVICE

THE COMMITTEE HAD PLANNED TO HOLD TODAY'S HEARING IN TWO PHASES. THE MORNING HEARING, WHICH WE HAVE HEARD HERE TODAY, LAID OUT THE CURRENT STATUS OF INDIAN HEALTH AND THE QUALITY OF HEALTH CARE DELIVERY IN INDIAN COUNTRY. THE AFTERNOON HEARING WOULD HAVE HIGHLIGHTED THE PRELIMINARY FINDINGS OF OUR COMMITTEE'S INVESTIGATION OF IHS, WITH TESTIMONY FROM OUR INVESTIGATOR AND WITNESSES FROM IHS ITSELF.

BECAUSE OF TWO DEVELOPMENTS THAT HAVE TAKEN PLACE OVER THE WEEKEND, WE HAVE BEEN FORCED TO CHANGE OUR SCHEDULE AND MUST PLAN TO PRESENT OUR FINDINGS AT A LATER DATE, AFTER FURTHER INVESTIGATION. BOTH OF THESE DEVELOPMENTS ARE QUITE DISTURBING, BECAUSE THEY INDICATE THAT -- UNLIKE EVERY OTHER FEDERAL AGENCY WE HAVE EXAMINED -- THE INDIAN HEALTH SERVICE HAS BEEN SINGULARLY UNCOOPERATIVE WITH OUR COMMITTEE'S INVESTIGATION.

IN THE COURSE OF THIS COMMITTEE'S WORK, WE HAVE EXAMINED THE BUREAU OF INDIAN AFFAIRS (BIA), THE BUREAU OF LAND MANAGEMENT (BLM), THE MINERALS MANAGEMENT SERVICE (MMS), THE SMALL BUSINESS ADMINISTRATION (SBA), THE DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT (HUD), THE ENVIRONMENTAL PROTECTION AGENCY (EPA), THE FISH AND WILDLIFE SERVICE, AND THE BUREAU OF RECLAMATION. ALTHOUGH THE NATURE OF OUR WORK WAS INVESTIGATIVE AND OUR

ULTIMATE FINDINGS WERE OFTEN CRITICAL, ALL OF THESE AGENCIES FULLY COOPERATED WITH OUR EFFORTS. THEY NOT ONLY OPENED THEIR OFFICES TO US, BUT HAVE ACTUALLY ENCOURAGED THEIR EMPLOYEES TO COME FORWARD.

THE BIA, FOR EXAMPLE, WROTE ITS EMPLOYEES EARLY IN THE LIFE OF THE INVESTIGATION AND TOLD THEM OF THE SECRETARY'S COMPLETE SUPPORT OF OUR WORK. MOREOVER, BIA EMPLOYEES WERE SPECIFICALLY TOLD THEY WERE FREE TO MEET WITH OUR INVESTIGATORS, IN CONFIDENCE, WITHOUT BEING REQUIRED TO TELL THEIR SUPERVISORS. THEIR LETTER, DATED JUNE 16, 1988, ALSO REMINDED EMPLOYEES OF THEIR RIGHTS TO COME FORWARD AND SPEAK FREELY.

THROUGHOUT OUR INVESTIGATION OF IHS, THIS LEVEL OF COOPERATION HAS BEEN LACKING. WHILE THE DIRECTOR, DEPUTY DIRECTOR AND ASSOCIATE DIRECTOR FOR ADMINISTRATION AND MANAGEMENT HAVE ALL SAT DOWN WITH US FOR LENGTHY DEPOSITIONS UNDER OATH, WE HAVE HAD REPEATED DIFFICULTIES WITH DOCUMENT PRODUCTION AND ACCESS TO LOWER-LEVEL EMPLOYEES.

THIS WEEKEND THE COMMITTEE RECEIVED INFORMATION SUGGESTING THAT A POSSIBLE WITNESS MAY HAVE BEEN SUBJECTED TO PRESSURE NOT TO FULLY COOPERATE WITH THE COMMITTEE. WE CLEARLY NEED TO INVESTIGATE THIS ALLEGATION BEFORE PROCEEDING FURTHER.

ON MARCH 2, 1989, WE REQUESTED EXTENSIVE DOCUMENTATION CONCERNING IHS HEADQUARTERS, AS WELL AS THE OKLAHOMA CITY AND

NASHVILLE AREA OFFICES. WE HAD RECEIVED FAR-REACHING ALLEGATIONS -- AND I STRESS THESE ARE ONLY ALLEGATIONS -- THAT THESE AREA OFFICES HAD CIRCUMVENTED NORMAL GOVERNMENT FINANCE AND PROCUREMENT PROCEDURES. WE HAVE NOT BEEN ABLE TO SUBSTANTIATE THESE ALLEGATIONS IN LARGE PART BECAUSE WE HAVE NOT BEEN GIVEN DOCUMENTS THAT WERE REQUESTED BY US IN EARLY MARCH.

ON AT LEAST THREE OCCASIONS SINCE THAT REQUEST, COMMITTEE ATTORNEYS HAVE SPOKEN WITH IHS HEADQUARTERS ABOUT THEIR FAILURE TO COMPLY WITH THIS REQUEST FOR DOCUMENTS. ON ONE OCCASION, IHS ASKED THAT WE NARROW OUR DOCUMENT REQUEST, AND WE COMPLIED WITH THEIR WISHES.

THE ONLY EXPLANATION THE COMMITTEE RECEIVED AS TO THE LENGTHY DELAY IN PROVIDING DOCUMENTS WAS GIVEN IN A SWORN DEPOSITION BEFORE THE COMMITTEE BY MILBURN HOWARD ROACH, ASSOCIATE DIRECTOR OF IHS. MR. ROACH TESTIFIED THAT IHS DELAYED RESPONDING TO THE COMMITTEE'S REQUEST FOR DOCUMENTS BECAUSE THE IHS HAD DECIDED TO GIVE AN "INTERIM RESPONSE... THAT WENT THROUGH AND FOUND ITS WAY TO THE DEPARTMENT [OF HHS], BUT FOR SOME REASON IT [THE RESPONSE] NEVER GOT OUT." DESPITE REPEATED QUESTIONING, MR. ROACH COULD NOT PROVIDE A CLEARER RESPONSE.

IT WAS NOT UNTIL FRIDAY EVENING, MAY 12, AT 6:20 P.M., LESS THAN 72 HOURS BEFORE THIS HEARING, THAT THE AGENCY PROVIDED US WITH ANY OF THE DOCUMENTS WE HAD REQUESTED. AT THAT TIME WE RECEIVED APPROXIMATELY SEVEN THOUSAND PAGES OF DOCUMENTS. THESE

DOCUMENTS CAME IN STACKS, WITH NO INDEX, NO NUMBERING SYSTEM, AND NO DISCERNIBLE METHOD OF ORGANIZATION.

ACCOMPANYING THOSE BOXES OF DOCUMENTS WAS A BRIEF NOTE FROM IHS' DIRECTOR OF LEGISLATION AND REGULATION WHICH SAYS, AND I QUOTE: "... AS ADDITIONAL MATERIAL IS SUBMITTED I WILL FORWARD IT TO YOU. I APOLOGIZE FOR THE DELAY." TO DATE, THIS IS THE ONLY WRITTEN RESPONSE WE HAVE RECEIVED IN THE TEN WEEKS SINCE WE MADE OUR REQUEST.

NO OTHER FEDERAL AGENCY OR COMPANY HAS EVER SUBMITTED DOCUMENTS TO US IN SUCH AN INCOMPLETE, INCOHERENT AND UNTIMELY FASHION. IN COMBINATION WITH THE OTHER ALLEGATIONS RECEIVED THIS WEEKEND, THE ONLY RESPONSIBLE ACTION AT THIS TIME IS TO POSTPONE UNTIL A LATER DATE THE SECOND PHASE OF TODAY'S HEARING.

SENATOR MCCAIN AND I HAVE INSTRUCTED OUR COMMITTEE STAFF TO CAREFULLY EXAMINE THE NEW DOCUMENTS RECEIVED FRIDAY EVENING AND TO TAKE FURTHER DEPOSITIONS UNDER OATH. IN ADDITION, WE WILL RENEW OUR REQUEST TO IHS FOR THE REMAINDER OF THE DOCUMENTATION THAT WE ORIGINALLY REQUESTED TWO AND A HALF MONTHS AGO. FURTHERMORE, IF THE COMMITTEE DOES NOT RECEIVE COOPERATION FROM THIS POINT FORWARD, WE WILL CONSIDER SUBPOENAING IHS FOR DOCUMENTS AND TESTIMONY. ALTHOUGH WE HAVE REFRAINED FROM SERVING SUBPOENAS ON OTHER FEDERAL AGENCIES, THE COMMITTEE WILL USE ITS POWER OF SUBPOENA IF IT IS NECESSARY TO CARRY OUT THE DUTIES VESTED IN US BY THE U.S. SENATE.

AND FINALLY, I WOULD LIKE TO SAY THAT THIS COMMITTEE HAS ALWAYS CONDUCTED THE MOST COMPREHENSIVE AND RIGOROUS POSSIBLE INVESTIGATION, NO MATTER WHO THE TARGET. WHETHER IT WAS TAPE RECORDING THE CHAIRMAN OF A TRIBAL COUNCIL OR CONDUCTING COVERT SURVEILLANCE OF OIL COMPANIES, OUR INVESTIGATIVE STAFF HAS TAKEN PAINS TO PRODUCE AN ACCURATE AND COMPLETE RECORD OF EVIDENCE. IN THE COURSE OF OUR ENTIRE INVESTIGATION, WE HAVE RECEIVED MORE THAN A MILLION PAGES OF DOCUMENTS FROM NATURAL RESOURCE AND OTHER COMPANIES, AS WELL AS GOVERNMENT AGENCIES. COMMITTEE STAFF HAVE ALWAYS EXAMINED ALL DOCUMENTS BEFORE CONDUCTING QUESTIONING IN PUBLIC HEARINGS.

TO PROCEED WITH THE QUESTIONING TODAY WITHOUT A MEANINGFUL OPPORTUNITY TO FULLY EXAMINE THE DOCUMENTS JUST SUBMITTED BY IHS FRIDAY EVENING WOULD BE NOT ONLY IRRESPONSIBLE, BUT A COMPLETE BREAK WITH OUR PAST PRACTICE AND PROCEDURE. WE WILL NOT ALLOW IHS TO ALTER OR COMPROMISE THE QUALITY AND INTEGRITY OF OUR INVESTIGATIVE PRACTICES.

THE COMMITTEE LOOKS FORWARD TO ITS FURTHER INVESTIGATION INTO THE VERY IMPORTANT MATTER OF INDIAN HEALTH. THIS INCLUDES, OF COURSE, THE TAKING OF FURTHER SWORN TESTIMONY FROM THE DIRECTOR OF THE INDIAN HEALTH SERVICE, SUBJECT TO COMPLETE QUESTIONING BASED ON ALL THE FACTS, AND NOT A PARTIAL RECORD. THIS MORNING'S TESTIMONY CLEARLY INDICATES THERE IS MUCH REASON FOR CONCERN IN THIS AREA.

[THE COMMITTEE WILL STAND IN RECESS UNTIL 10:00 A.M. TOMORROW MORNING.]

QUESTIONS FOR FRED MATT

1. Why was the Intertribal Timber Council formed?

2. Does ITC have a technical arm or does it rely on the BIA for its figures? What problems does this create for the ITC? What is the relationship between the ITC and the BIA? What changes should be made to improve efficiency and its accomplishment?

3. At the present time, would you describe the current climate in the timber market? Are the tribes being held back from putting on timber sales? What is necessary in order to make sales occur more easily?

4. Are the tribes running into trouble in marketing timber? What are potential solutions to the problem?

5. With regard to the nature of the federal government's trust obligations, what is the minimum acceptable level necessary to meet the trust obligation?

6. What do tribes contribute to forestry programs?

7. If the BIA is not meeting its trust responsibility, why don't the tribes just file litigation for mismanagement?

8. Has the Flathead Reservation been able to harvest its maximum allowable cut?

9. What is the future role for the ITC?

STATEMENT OF SENATOR DASCHLE

SPECIAL COMMITTEE ON INVESTIGATIONS

INDIAN HEALTH SERVICE HEARING

THANK YOU, MR. CHAIRMAN. RECENTLY I READ AN EXCERPT FROM THE PRESIDENT'S SPECIAL MESSAGE TO CONGRESS ON INDIAN HEALTH, AND I WOULD LIKE TO SHARE A QUOTE FROM THAT REPORT WITH YOU. THE PRESIDENT WROTE, AND I QUOTE:

> "IN MANY PARTS OF THE INDIAN COUNTRY, INFANT MORTALITY, TUBERCULOSIS, AND DISASTROUS DISEASES GENERALLY PREVAIL TO AN EXTENT EXCEEDED ONLY IN SOME OF THE MOST INSANITARY OF OUR WHITE RURAL DISTRICTS AND IN THE WORST SLUMS OF OUR LARGE CITIES.... AS GUARDIANS OF THE WELFARE OF THE INDIANS... IT IS OUR IMMEDIATE DUTY TO GIVE [THEM] A FAIR CHANCE FOR AN UNMAIMED BIRTH, HEALTHY CHILDHOOD, AND A PHYSICALLY EFFICIENT MATURITY."

AS A SENATOR FROM A STATE WITH A LARGE INDIAN POPULATION, THE PRESIDENT'S STATEMENT RINGS VERY TRUE TO ME AS I SIT HERE TODAY. BUT THE PRESIDENT WHO WROTE THOSE WORDS WAS NOT GEORGE BUSH. IT WAS, RATHER, WILLIAM HOWARD TAFT, WRITING ALMOST SEVENTY-SEVEN YEARS AGO.

THE SAD TRUTH IS THAT, EVEN THOUGH TREMENDOUS STRIDES HAVE BEEN MADE IN INDIAN HEALTH OVER THE LAST SEVERAL DECADES, NATIVE AMERICANS ARE STILL FAR FROM PARITY WITH THE GENERAL U.S.

POPULATION. AS WE WILL HEAR SOON FROM DR. DOUGHERTY OF THE OFFICE OF TECHNOLOGY ASSESSMENT, AN INDIAN PERSON IS AT LEAST TWICE AS LIKELY AS THE AVERAGE AMERICAN TO DIE FROM DIABETES, PNEUMONIA, KIDNEY FAILURE, HOMICIDE, ACCIDENTS OR LIVER DISEASE.

WHEN PRESIDENT TAFT TURNED HIS ATTENTION TO THESE PROBLEMS EARLY IN THE 20TH CENTURY, HIS SOLUTION WAS SIMPLE: HE ASKED FOR AN ADDITIONAL APPROPRIATION OF $253,350 FOR THE INDIAN MEDICAL SERVICE. TODAY THE INDIAN HEALTH SERVICE SPENDS THAT MUCH MONEY ON AVERAGE EVERY TWO HOURS.

BUT APPROPRIATING MORE MONEY IS NOT, IN AND OF ITSELF, A SOLUTION TO THE HEALTH NEEDS FACING AMERICAN INDIANS TODAY. WE, AS MEMBERS OF THE U.S. SENATE, HAVE A SPECIAL RESPONSIBILITY TO SEE THAT THE FUNDS WE APPROPRIATE ARE GOING TO THEIR BEST POSSIBLE USE. ALTHOUGH SHORTFALLS IN THE STATUS OF INDIAN HEALTH MAY CRY OUT FOR ADDITIONAL SPENDING, WE MUST ASSURE THE AMERICAN INDIANS AND THE AMERICAN TAXPAYERS THAT THE INDIAN HEALTH SERVICE IS HELD ACCOUNTABLE FOR FUNDS WE HAVE ALREADY APPROPRIATED. IT IS TO THAT TASK THAT THIS COMMITTEE IS DEDICATED.

TESTIMONY OF DENISE DOUGHERTY, PH.D.
U.S. CONGRESS OFFICE OF TECHNOLOGY ASSESSMENT

BEFORE THE
U. S. SENATE SELECT COMMITTEE ON INDIAN AFFAIRS
SPECIAL COMMITTEE ON INVESTIGATIONS

INDIAN HEALTH

MAY 15, 1989

Mr. Chairman, I am pleased to appear before you to present testimony to the Committee. You have asked OTA to provide some context for the hearings you are holding today by (1) briefly describing the Indian Health Service and presenting (2) OTA's analyses of the state of Indian health and of the adequacy of the Federal health services delivery system for Indians.

Much of my testimony will be based on the findings in OTA's full assessment, Indian Health Care, published in April 1986 (U. S. Congress, Office of Technology Assessment, 1986),[1] updated where possible. This assessment, begun in 1984, was requested by the House Energy and Commerce Committee and its Subcommittee on Health and the Environment; the request was also supported by the Senate Select Committee on Indian Affairs. Those committees were concerned that the health of Indian people appeared to continue to lag behind that of the rest of the U. S. population. They asked us to examine the health status of Indians and the services and technologies that are provided to them through Federal Indian health programs.

Our review focused on services provided by the Federal Indian Health Service (IHS) and the health status of Indians served by the IHS.

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1 OTA followed this full assessment with a special report to Congress on clinical staffing in the Indian Health Service (U. S. Congress, OTA, February 1987).

The Indian Health Service

The U. S. Department of Health and Human Services (USDHHS), primarily through the Indian Health Service (IHS) of the Public Health Service (PHS), is responsible for providing Federal health services to American Indians and Alaska Natives. Federal Indian health services are based on the laws which the Congress has passed pursuant to its authority to regulate commerce with the Indian Nations as explicitly specified in the Constitution and in other pertinent authorities (USDHHS, PHS, IHS, April 1988).[2] The goal of the IHS program is to raise the health status of American Indians and Alaska Natives to the highest possible level (Indian Health Care Improvement Act [Public Law 94-437 as amended]; USDHHS, PHS, IHS, 1988, 1989a). IHS defines its service delivery responsibilities to include a comprehensive range of inpatient and ambulatory medical services, dental care, mental health and alcoholism services, preventive health (immunizations and environmental services such as sanitation and water safety), health education, and Indian health staff development programs (U. S. Congress, OTA, 1986).

IHS provides these health and health-related services to eligible Indians in a variety of ways. The approximately 1 million Indians (USDHHS, PHS, IHS, 1988, February 21, 1989)[3] who live on or near reservations are

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2 Social and health services have been provided to Indian tribes since the time the United States became an independent nation. Until 1921, when the Snyder Act (42 Stat. 208; 25 U.S.C. section 13) was passed, Congress provided funds without specific authorization. Since 1921, the Snyder Act has been the basic authorizing mechanism to provide funds for Indian health services (U. S. Congress, OTA, 1986). However, while Congress has consistently provided funds for Indian service programs, the courts so far have ruled that these benefits are voluntarily provided by Congress and not mandated under the Federal Government's trust responsibility for Indian tribes. Appropriated funds are "public moneys" and not treaty or tribal funds "belonging really to the Indians" (*Scholder v. United States*,428 F. 2d 1123 [9th Cir., 1970], *cert. denied*, 400 U.S. 942 [1970].

3 The exact number of Indians in the service population is not known with certainty (U. S. Congress, OTA, 1986).

theoretically eligible to receive the comprehensive range of services at no cost to the individual Indian, regardless of other health insurance coverage or ability to pay. This program of services is provided in facilities owned and operated by IHS, and is known as the *direct care program*.

Although in principle IHS services are comprehensive and readily available at no user cost, in fact they are limited by IHS budget constraints and by the uneven distribution of services among IHS areas that has developed over the years (U. S. Congress, OTA, 1986). When no IHS facility is accessible or when specific services are not available from IHS facilities, Indian patients may require referral to private providers under the IHS *contract care program*. It is important to note that contract care is a separate item in the overall IHS budget, and that contract care budgets sometimes have been so limited that needed referrals cannot be made. Thus, while they may not be directly affected by ability to pay, Indians may face serious obstacles in obtaining health care services through IHS. Another obstacle to obtaining contract care is that eligibility for such services is more restricted than for direct care.

Another factor in the IHS delivery system since the Indian Self-Determination and Education Assistance Act of 1975 (Public Law 93-638), amended in 1988 (Public Law 100-472), has been the operation of health facilities and service programs by Indian tribes. Direct care facilities, contract care programs, facilities construction, and special programs such as community health representatives, mental health and drug abuse, and health education initiatives may be administered by tribes under *self-determination or 638 contracts*. Most of these services, like IHS's own services, are reservation based, and they are provided to IHS-eligible Indians at no cost to the individual. But Indian tribes may also use non-Federal sources of payment, and may treat non-Indians (U. S. Congress, OTA, 1986).

About half of Indians today reside in urban areas rather than on reservations.[4] However, *urban Indian health projects* operate separately from the reservation-based IHS system. Unlike IHS-direct programs, urban projects may receive funds from non-IHS sources, are likely to treat non-Indians, and may request payment from Indians and non-Indians alike based on a sliding fee scale. Urban projects are similar to tribally operated programs in that they are more active than IHS programs in treating and billing non-Indians and in coordinating their efforts with other non-IHS health delivery programs (U. S. Congress, OTA, 1986). Primarily, urban programs must be more active in securing other funds because IHS only partially supports urban programs.

Although IHS programs provide health, dental, mental health, alcoholism, and preventive health services, most of IHS's resources are, apparently of necessity, used to provide hospital-based and ambulatory services for acute and chronic physical conditions. As shown in table 1, for example, $723 million (77 percent) of IHS's total budget of $935 million was used for hospitals and clinics, exclusive of dental, mental health, and alcoholism services. Another 9 percent of the budget was used for direct clinical dental, mental health, and alcoholism treatment services: 3 percent for direct and tribal dental services, 1.3 percent for direct and tribal mental health services, and 3.1 percent to direct and tribal alcoholism services. $183 million of the clinical budget (25 percent of the clinical budget) was used to provide contract care services.[5]

Seven percent of IHS's budget was used for preventive health services (that is, sanitation, public health nursing, health education, community health representatives, and immunizations) in fiscal year 1988. $9.6 million

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4 Historical reasons for this are discussed in U. S. Congress, OTA, 1986.
5 Some contract care funds are used for dental, mental health, and alcoholism services.

Table 1.--IHS Allocations by Budget Category Fiscal Year 1989

Activity/Sub-activity	Total area allocations	Percent of total
Clinical Services:		
Hospital & clinics	$533,614,000	57%
Dental	$28,974,000	3%
Mental Health	$12,466,000	1%
Alcoholism	29,335,000	3%
Maintenance & Repair	11,359,000	1%
Reimbursements	6,227,370	--[1]
Total health delivery	$621,975,370	66%
Contract care	183,481,000	19%
Total clinical services	$805,456,370	86%
Preventive health:		
Sanitation	$23,907,000	3%
Public health nursing	14,113,000	2%
Health education	4,413,000	--
Community health reps	27,282,000	3%
Immunization	395,000	--
Total preventive health	$70,110,000	7%
Urban projects	$9,624,000	1%
Indian health manpower	$7,646,000	1%
Tribal management	$3,094,000	--
Direct operations	$39,104,000	4%
Total allowances issued	$925,034,000	100%

[1]less than 1 percent of total

SOURCE: USDHHS, PHS, IHS, "Fiscal Year 1990 Justification of Appropriation Estimates for Committee on Appropriations, Volume XI--Indian Health." (Washington, DC: U.S. Department of Health and Human Services, Public Health Service, 1989).

(1.2 percent) of IHS's total budget was allocated to 35 urban projects. Although it is not shown separately in Table 1, approximately $218 million was used to support Indian self-determination (638) grants and contracts in fiscal year 1988. Approximately the same proportions are expected to be allocated in fiscal year 1989 (USDHHS, PHS, IHS, 1989).

Organizationally, IHS comprises 12 regional administrative units called Area Offices (see figure 1).[6] Currently, the Area Offices oversee 127 basic administrative units called Service Units. Of the 127 service units, 52 are operated by tribes (see figure 2). IHS operates 43 hospitals, 131 health centers and stations, and 37 other treatment locations (figure 3), while tribes operate 7 hospitals, 313 health centers and stations, and 11 other treatment locations (figure 2) (USDHHS, PHS, IHS, February 21, 1989). Thirty-five urban health projects are partially supported by IHS (figure 4). With the partial exception of the urban projects, IHS facilities are concentrated in the Western part of the nation, where most reservation-based Indians live (figure 5).

Indian Health Status

OTA's 1986 report may be the most extensive and detailed analysis of Indian health status extant. What distinguished our analysis most from previous reviews was the fact that we computed age-adjusted mortality rates for each IHS service area and for service areas overall. Although a number of caveats obtain, age-adjusted mortality rates appear at present to provide the single best way to compare Indian health status with that of the rest of the U. S. population. OTA also used information from IHS's patient care

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6 Technically, the IHS office in Tucson is a headquarters office for the Office of Health Program Development, which is responsible for administering health services delivery. For statistical purposes, IHS considers Tucson an Area Office (IHS, April 1988.

Figure 1

Indian Health Service
DHHS/PHS

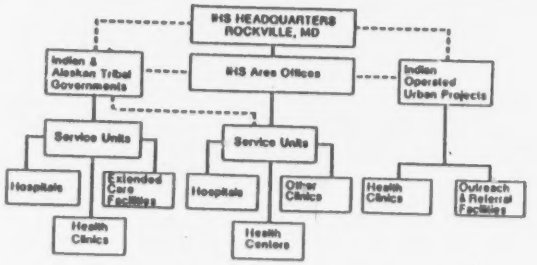


Figure 2

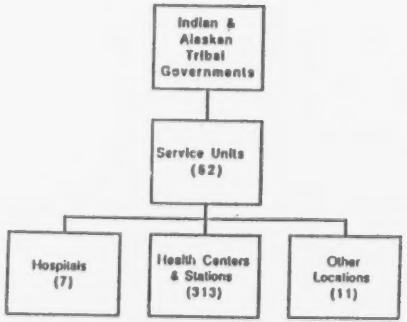


Figure 3

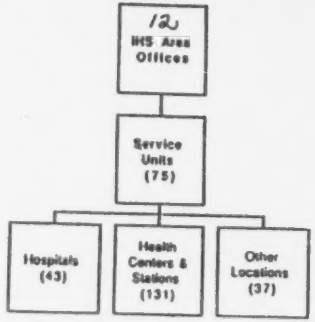


Figure 4

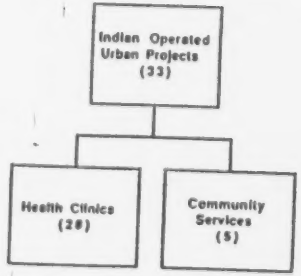
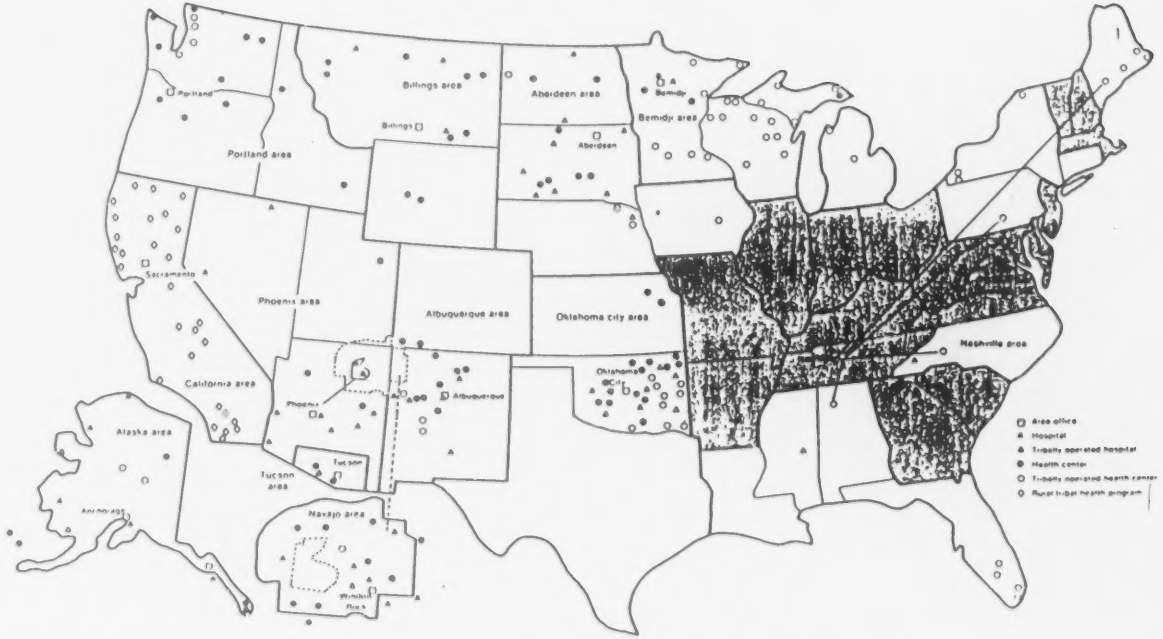


Figure 5. - Indian Health Facilities



SOURCE: U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Indian Health Service, 1985.

information systems to indicate what conditions were responsible for hospitalizations and clinical treatment of Indians, but these data are somewhat less reliable as comparative indicators of health status for a number of reasons (U. S. Congress, OTA, 1986). Many features of IHS's data collection system differ from that of other health care providers; the IHS service delivery system has too many unique features to be directly comparable to other health care delivery systems, whether public or private (such as the Veterans Administration or HMOs[7]); and service utilization data may reflect access rather than health status. Little epidemiologic data has been collected concerning Indians.

The fact that OTA limited its analysis of Indian health status data to the IHS service population is also unusual. IHS publishes a "chart series" each year with analyses of mortality rates, but, in order to have figures comparable with earlier rates[8], IHS computes its overall mortality rate based on mortality and population information for all Indians in 28 reservation States, rather than the population eligible for service from IHS. Another factor that has limited IHS's use of service population mortality statistics is a problem in estimating the age and sex distribution of the Indian service population between census years (see U. S. Congress, OTA, 1986, for a discussion).

Apparently because Indians who do not live on or near reservations have become more like the rest of the U. S. population in terms of socioeconomic status and health, the Indian mortality rates published by IHS, based on a

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7 See U. S. Congress, OTA, February 1987, for a discussion of the similarities and differences between the IHS system and HMOs.
8 Specifically those from 1955, when IHS became responsible for providing Indian health care but IHS service areas as they are now known had not been organized.

wider population of Indians, compare more favorably with that of the U. S. population in general than does a comparison between the IHS service population and the U. S. population in general.[9,10] IHS agrees that area-specific data are more appropriate to report, and when IHS completes the development of a method for estimating intercensus service populations by age and sex, they will begin to publish such data in their annual charts (D'Angelo, personal communication, 1989).

Some time after OTA began its Indian health assessment, IHS began its own review of Indian health status using a variety of measures. The impetus for this report was a directive from the House Committee on Appropriations that the Administration identify the "funding that would be required to bring the level of Indian health care services up to 'parity' with the U.S. population in general" (quoted in USDHHS, PHS, HRSA, IHS, June 1986a). This report, known widely as the "Gap report," used the same methodology as OTA did to compute area-specific mortality rates.[11] The Gap report used mortality data that was a year more recent than OTA was able to use. However, the GAP

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9 For example, the IHS Chart Series published a 1981 mortality rate of 568.9 per 100,000 population for Indians in reservation States. This was close to the U. S. all races rate for 1981 of 568.2 deaths per 100,000 population. In comparison, the average rate for the estimated IHS service population was 778.3 deaths per 100,000 population.

10 IHS periodically compiles service-area-specific health status information for its internal program review. The mortality rates used in these reports are not age-adjusted, however. It is important to use age-adjusted mortality rates because the Indian population is so much younger on average than the U.S. general population (see U. S. Congress, OTA, 1986, for a more extensive discussion of this issue).

11 It also contains a variety of other measures of utilization and health status.

report has not been published in final form, and so OTA is reluctant to cite specific figures from it. In general, however, its mortality results, even though somewhat more recent than OTA's, are quite similar to OTA's.[12]

Overall indications of Indian health status

As is summarized graphically in figure 6 and in the other figures I will present, OTA's analysis of mortality rates found that, despite substantial improvements in Indian health status (figure 7), the gap between the health of the IHS service population and the health of the U. S. general population remains alarmingly wide.

In the 3-year period centered in 1981, only one IHS service area, Oklahoma City, had an age-adjusted death rate that was below that of the U. S. all race population.[13,14] All other service areas had overall age-adjusted mortality rates well above that of the U. S. all races population.[15]

Perhaps the most significant indicator of Indian health status is that Indians do not live nearly as long as other U.S. populations. In the 3-year period centered in 1981, 37 percent of Indian deaths occurred in Indians younger than age 45, compared with only 12 percent of U. S. all races deaths occurring in that age group. Figure 8 shows that the mortality rate for

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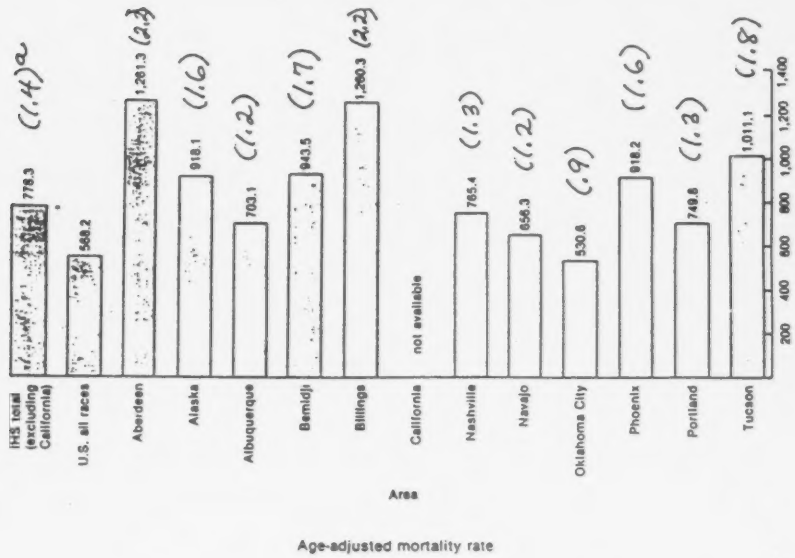
12 Mortality rates for 9 of the 11 areas reviewed in both reports declined between the 1980-1982 period used by OTA and the 1981-1983 period used by IHS in the Gap report. In two areas, overall mortality rates increased. A companion report to the Gap report provides substantial additional detail (e.g., mortality rates by cause by area) (USDHHS, PHS, HRSA, IHS, June 1986b). OTA was not able to review this report in detail in the time provided before this testimony. IHS plans to publish the companion report in the near future (D'Angelo, personal communication, 1989).

13 Data on the California service area was omitted from the analysis because the data are too incomplete to support any conclusions (see U. S. Congress, OTA, 1986, for discussion).

14This most likely reflects the fact that the Oklahoma Indian population resides in an urban area where health care is more easily obtained.

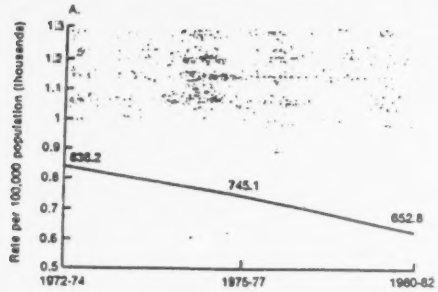
15 This includes Indians, but because Indians are such a small fraction of the population, the figures are not significantly biased by their inclusion.

Figure 6. - Age-Adjusted Death Rates: American Indians, 1980-82 12 IHS Areas: Both Sexes
(rates per 100,000 population in specified group)

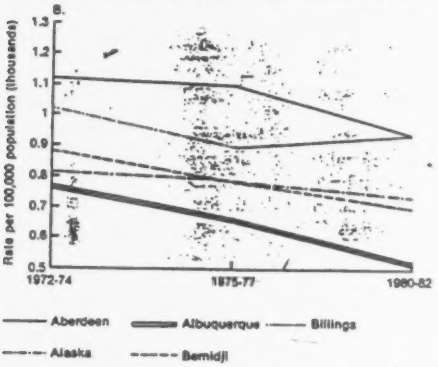


[a]Numbers in parentheses are ratios of IHS areas to U.S. all races mortality rates.

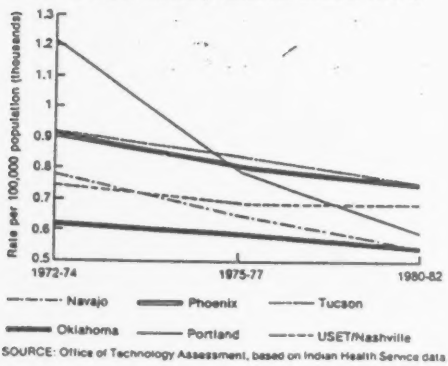
Figure 7. - All Areas Crude Mortality Rates
All Causes, 1972-85



IHS Area Crude Mortality Rates All Causes, 1972-82



IHS Area Crude Mortality Rates All Causes, 1972-82



SOURCE: Office of Technology Assessment, based on Indian Health Service data

Indians 1- to 4-years-old is 2.2 times that of the U. S. all races population of that age. Fifteen- to 24-year-old Indians die at almost 3 times the rate of other Americans in that age group, and 25- to 34-year old Indians do die at 3 times the fate of other Americans in their age group.

The infant mortality rate for Indians has declined significantly over time, but, after they reach one month of age, Indian infants are still more likely to die than babies born to other Americans (figure 9).[16]

A look at the causes of death for Indians explains in part why Indians tend to die at much younger ages than their fellow citizens, although even diseases which are characteristic of most older people can be found among younger Indians (e.g., heart disease, pneumonia; see U. S. Congress, OTA, 1986, Appendix B, for age-specific rates). Indians are particularly vulnerable to the so-called "social" or external causes of death (figure 10). Accidents, particularly motor vehicle accidents, kill Indians at 3.4 times the rate of the U. S. all races population. Long distances between destinations, poor roads, overcrowded and unsafe vehicles, and driving under the influence of alcohol are among the major causes of motor vehicle accidents among Indians. Indians die as a result of homicide at twice the rate of the U. S. all races population, and commit suicide at 1.7 times the rate of the U. S. all races population.

Alcohol abuse is implicated in these external causes of death, as well as in many other causes of mortality (diabetes, congenital anomalies in infants, pneumonia, heart disease, and cancer). The extent of alcohol abuse

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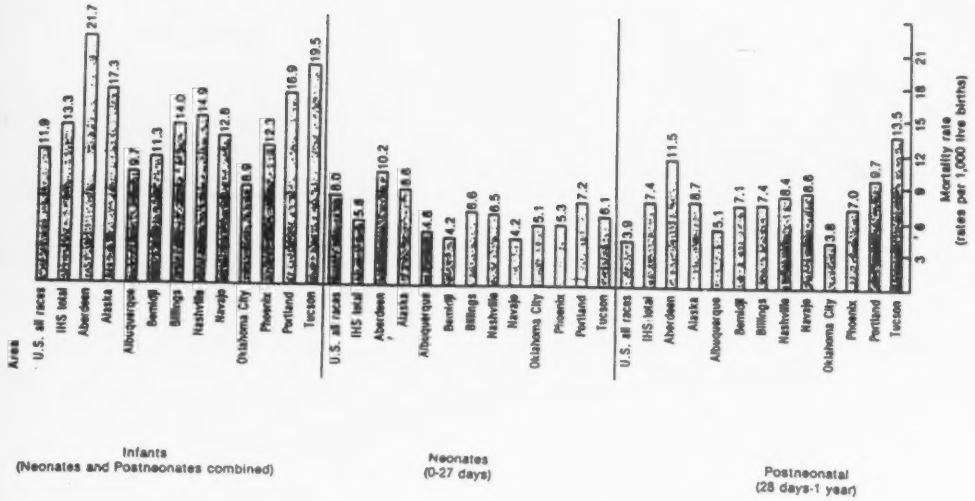
16Significant progress has been made in serving the youngest infants (less than 28 days old), for whom the overall Indian mortality rate (5.8 per 1,000 live births) is less than that of the U. S. all races (8.0 per 1,000 live births), but after newborns have been returned to their communities for a while, the mortality rate (7.4 deaths per 1,000 live births) becomes double that of U. S. all races rate (3.9 deaths per 1,000 live births).

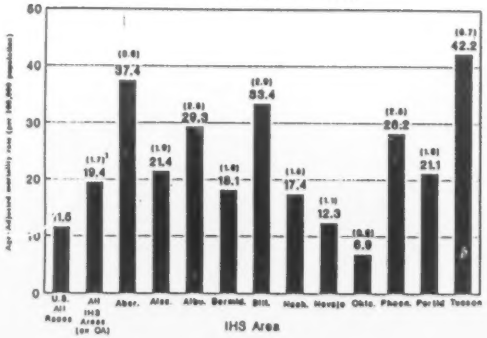
- Figure 9. - Infant Mortality Rates American Indians in IHS Areas 1980-82 and U.S. All Races, 1981



SOURCE: Office of Technology Assessment, April 1986

Figure 10

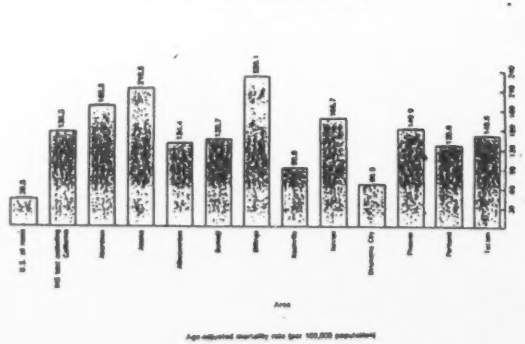
Indian Suicide
1980-1982
Compared to U.S. All Races 1981



¹Ratio of Indians to U.S. All Races for Suicide Mortality.

Source: OTA, based on IHS and NCHS data.

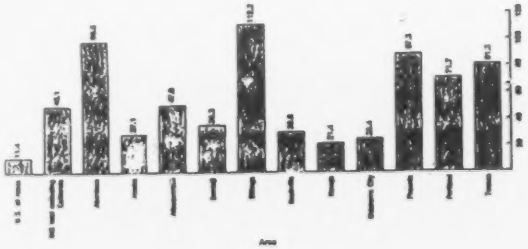
Age-Adjusted Death Rates for Accidents and Adverse Conditions, American Indians in 11 IHS Areas (excluding California) 1980-82



Area

Age-adjusted mortality rate (per 100,000 population)

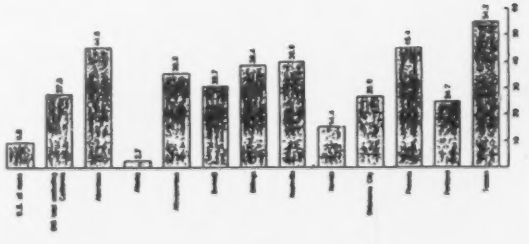
Age-Adjusted Death Rates for Liver Disease and Cirrhosis, American Indians in 11 IHS Areas (excluding California) 1980-82



Area

Age-adjusted mortality rate (per 100,000 population)

Age-Adjusted Death Rates for Homicide, American Indians in 11 IHS Areas (excluding California) 1980-82



Area

Age-adjusted mortality rate (per 100,000 population)

can be seen in the overall mortality rate for liver disease and cirrhosis: 4.2 times the U. S. all races age-adjusted rate. What is perhaps more disturbing is the fact that, while in the general population the death rate from liver disease begins to climb beginning in the 25- to 34-year old age group, and peaks in the 65- to 74- year age group, among Indians aged 25 to 34 the liver disease death rate is about what it is for the general population aged 55 to 64, and the death rate peaks between ages 45 and 54. Even those Indians ages 15 to 24 have a death rate from liver disease that is eight times that of the U. S. all races population of that age.

The other causes of early death that have not yet been controlled relative to the U. S. population at large include pneumonia and influenza, diabetes, nephritis (kidney disease), congenital anomalies, septicemia (systemic infection), and tuberculosis[17] (see table 2).

OTA found other important Indian health problems reflected in epidemiological surveys and patient care data. Used cautiously, IHS inpatient and outpatient utilization statistics may be applied to supplement an evaluation of Indian health status. For example, IHS patient care utilization data indicate that otitis media is a severe problem among Indian children. Untreated otitis media can cause serious hearing loss and could be a cause of low school achievement among some Indian children (U. S. Congress, OTA, April 1986). Hypertensive disease (high blood pressure), diabetes, lacerations and open wounds, and eye disorders are also among the most common causes of visits to IHS outpatient clinics.

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17 In 1980-82, tuberculosis was found mostly among elderly Indians.

Table 2.-- Leading Causes of American Indian Deaths and Age-Adjusted Death Rates for All IHS Areas (excluding California) (1980-82), Compared to Age-Adjusted Death Rates for U.S. All Races (1981)

IHS code[a]	Rank[b]	Cause name	American Indian		U.S. all races	Ratio
			Number of deaths	Age-adjusted rate[c]	Age-adjusted rate	American Indian to U.S. all races
ALL	...	All causes	15,321	778.3	568.2	1.4
310	1.	Diseases of the heart	3,058	166.7	195.0	0.9
790	2.	Accidents/adverse effects	2,946	136.3	39.8	3.4
150	3.	Malignant neoplasms	1,713	98.4	131.6	0.7
620	4.	Liver disease/cirrhosis	801	48.1	11.4	4.2
430	5.	Cerebrovascular diseases	664	33.8	38.1	0.9
510	6.	Pneumonia/influenza	580	26.6	12.3	2.2
260	7.	Diabetes mellitus	470	27.8	9.8	2.8
830	8.	Homicide	458	21.2	10.4	2.0
820	9.	Suicide	447	19.4	11.5	1.7
740	10.	Perinatal conditions	331	9.8	9.2	1.1
640	11.	Nephritis, et al	229	12.4	4.5	2.8
730	12.	Congenital anomalies	205	6.5	5.8	1.1
540	13.	Chronic pulmonary diseases	177	9.6	16.3	0.6
090	14.	Septicemia	122	6.5	2.9	2.2
030	15.	Tuberculosis	77	4.2	0.6	7.0
		All others	2,910	144.4	67.5	2.1

[a]Comparable to ICD-9 Codes; available from IHS.
[b]Ranked by number of deaths.
[c]Note that age and sex distributions are for reservation States and may or may not reflect age and sex distribution in IHS areas.

SOURCES: U.S. All Races: U.S. Department of Health and Human Services, Public Health Service, National Center for Health Statistics, "Advance Report, Final Mortality Statistics, 1981," *Monthly Vital Statistics Report* 33(3):Supp., DHHS Pub. No. (PHS) 84-1120 (Hyattsville, MD: PHS, June 22, 1984); Indians in IHS areas: U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Indian Health Service, computer tape supplied to the Office of Technology Assessment, 1985.

Consistent with the mortality and other data, hospital discharge rates for Indians are higher than that for the U. S. general population for serious alcohol abuse, complications of pregnancy, injuries and poisonings, pneumonia, otitis media, diabetes, infectious and parasitic diseases, and conditions arising in the perinatal period (table 3).

Differences in health status by area

It is important to note that national averages of Indian mortality and illness rates may mask important differences among service areas. For example, the Indian service areas with the highest overall mortality rates experience mortality at 1.6 times the rate of IHS areas on average, and 2.2 times the rate of the U. S. all races population (figure 6). Similarly, the causes of mortality, hospitalization (table 3), and use of outpatient clinics differ among service areas.[18] While all service areas have a mortality rate from accidents that exceeds the U. S. all races rate (figure 10), the most serious problems from heart disease[19] are concentrated in four service areas (Aberdeen, Bemidji, Billings, and Nashville) (figure 11). It is important to keep in mind, however, that when utilization differs among regions, it may be more reflective of the lack of available services than lack of need for them (U. S. Congress, OTA, 1986). Thus, utilization data are not an entirely reliable indicator of illness among Indians.

Adequacy of the IHS health care delivery system

Both the comprehensiveness of the services IHS provides and the absence of premiums and user charges for IHS services set Indians apart from the general population in terms of their health care delivery expectations and

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18 See U. S. Congress, OTA, 1986 for detailed lists of outpatient utilization by area.
19 Reflected in mortality rates.

Table 3.--Estimated Hospital Discharge Rates, U.S. Non-Federal Short-Stay Hospitals, Calendar Year 1984 and IHS Hospitals[a] Federal Fiscal Year 1984 in Order by U.S. Hospital Discharge Rate
(rate per 10,000 population)

Principal diagnosis	ICD-9-CM code	U.S.	IHS	Aberdeen	Alaska[b]	Albuquerque	Bemidji	Billings	Nashville[c]	Navajo[d]	Oklahoma[e]	Phoenix	Portland	Tucson
Circulatory system disease	390-459	238.8	82.7	121.0	74.7	53.3	50.8	124.2	30.9	42.3	80.2	72.4	35.2	38.6
Complications of pregnancy, including normal	630-676	205.7[f]	347.0	407.0	354.9	252.3	70.8	341.8	90.8	390.9	348.7	343.3	86.8	183.2
Complications		138.5	220.0	324.0	280.4	58.0	50.2	218.1	52.7	328.0	293.7	287.4	51.2	148.8
Normal		67.2	85.0	83.0	64.7	194.3	19.1	123.7	38.1	64.9	55.0	55.9	35.6	34.4
Digestive system diseases	520-579	183.6	112.0	192.0	140.5	150.4	51.7	178.0	57.8	117.2	114.1	148.5	50.2	85.0
Alcoholic liver disease	571.0-571.3	1.6	4.4	6.9	1.9	7.0	0.9	12.5	0.3	2.8	3.6	12.0	1.3	9.0
Injuries and poisonings	800-999	148.1	150.8	297.0	243.2	161.5	63.0	283.2	57.8	142.8	74.8	286.7	62.8	115.4
Diseases of the respiratory system	460-519	143.5	114.0	252.0	155.9	115.8	54.0	197.5	71.7	100.3	71.9	200.1	50.3	95.8
Pneumonia	480-486	35.7	50.0	120.7	64.0	54.3	21.3	83.3	18.9	50.2	24.4	91.7	19.4	58.6
Asthma	493	19.8	13.5	21.9	15.0	11.9	11.0	21.7	10.2	9.2	13.8	31.5	4.4	4.5
Genitourinary system disease	580-629	132.9	65.4	114.0	79.3	67.6	18.9	103.5	37.7	59.7	70.4	115.7	23.9	26.9
Neoplasms	140-239	109.9	26.5	41.8	58.3	33.0	12.8	48.8	8.4	22.5	29.7	25.1	10.1	5.0
Malignant	140-208	87.8	16.8	31.0	44.1	24.6	10.8	38.9	5.8	15.6	18.1	16.9	6.1	4.5
Diseases of the musculoskeletal system	710-739	101.3	32.8	48.0	79.8	34.0	14.4	65.8	13.7	21.4	22.0	54.2	18.6	24.1
Mental disorders	290-319	72.1	57.0	177.0	98.8	104.5	23.6	118.2	45.4	38.3	27.0	59.0	17.5	38.1
Alcohol dependence syndrome	303	18.7	23.3	101.3	45.0	43.3	9.1	46.9	10.2	4.3	9.8	20.0	6.4	9.5
Alcoholic psychoses	291	2.3	10.1	18.0	8.9	34.0	5.1	21.4	5.4	0.4	5.3	15.2	1.5	5.6
Nondependent alcohol abuse	305.0	3.4	3.4	7.0	7.0	3.7	1.9	9.7	—	1.4	1.8	4.0	2.8	6.7
Diseases of the nervous system and sense organs	320-389	71.2	50.0	79.1	121.9	41.2	11.5	78.5	22.1	55.2	29.4	79.2	17.2	19.0
Otitis media	381.0-381.4, 382	12.8	18.0	31.0	83.9	10.5	3.6	29.9	5.1	16.7	10.8	23.8	4.6	7.8
Endocrine, nutrition, metabolic diseases	240-279	48.6	37.3	78.0	21.0	53.1	26.2	69.3	31.5	25.6	34.8	84.9	14.6	61.6
Diabetes mellitus	250	23.3	26.2	60.0	9.2	30.8	20.6	54.1	14.7	16.5	23.5	49.4	9.0	53.2
Infectious and parasitic diseases	001-139	28.1	31.6	49.0	31.6	30.1	8.7	44.8	18.2	28.6	22.8	87.0	10.9	50.4
Tuberculosis, all forms	010-018	10.8	2.4	6.8	4.0	1.8	0.8	3.7	0.3	2.6	1.4	4.0	0.1	2.8
Diseases of the skin and subcutaneous tissue	680-709	24.2	29.8	68.4	33.8	35.3	11.7	47.4	23.4	25.2	18.8	58.0	8.7	31.4
Cellulitis and abscesses, excluding digital	682	10.1	17.0	39.8	18.0	23.6	6.6	29.8	17.0	15.3	9.7	31.0	5.9	24.6
Symptoms, signs, and ill defined conditions	780-799	22.2	57.0	110.0	75.0	74.2	33.8	99.7	58.1	40.8	55.8	90.9	18.6	47.1
Supplementary classification	V01-V82[g]	19.4[g]	84.5	105.0	73.8	128.5	51.9	91.8	82.4	67.7	38.8	96.5	4.7	71.7
Diseases of the blood and blood-forming organs	280-289	15.1	8.8	17.3	8.5	8.4	0.2	9.0	5.5	4.8	7.7	8.7	2.5	9.0
Congenital anomalies	740-758	13.5	8.4	10.8	15.2	11.2	2.3	11.5	1.1	11.8	6.5	13.6	1.7	2.8
Conditions arising in perinatal period	760-779	7.1	22.4	30.9	38.2	22.7	7.4	24.2	4.2	33.7	14.7	37.7	5.5	18.5
Short gestation, low birthweight disorders	765	2.3	5.2	4.7	24.6	1.7	1.1	0.2	1.3	10.9	2.7	6.4	1.2	1.2
All[h]		1,565.1	1,210.1	2,199.0	1,702.5	1,374.1	505.7	1,934.6	625.9	1,228.6	1,069.1	1,837.5	437.8	913.6

[a]Direct, contract general and, where noted, two tribally run hospitals (Bristol Bay, Alaska area, and Choctaw, Nashville/USET program).

[b]Major diagnostic categories include discharges and service population for Bristol Bay "638" hospital and Bristol Bay Service Unit; subcategories do not. All rates exclude discharge data and estimated service population for Norton Sound "638" hospital and service unit.

[c]Major diagnostic categories include discharges for Choctaw "638" hospital and service population for Choctaw service unit.

[d]Rate excludes 578 discharges from Ganado, a tribally operated hospital, but does not exclude Ganado's service population. The 578 discharges constitute a small percentage of Navajo area hospitalizations (19,904 excluding Ganado).

[e]Excludes discharges from and service population for Claremore Hospital which is tribally operated.

[f]Includes "females with deliveries" (ICD-9-CM code V27), because IHS includes these discharges with "complications of pregnancy" instead of in the supplementary classification as NCHS does (see note g).

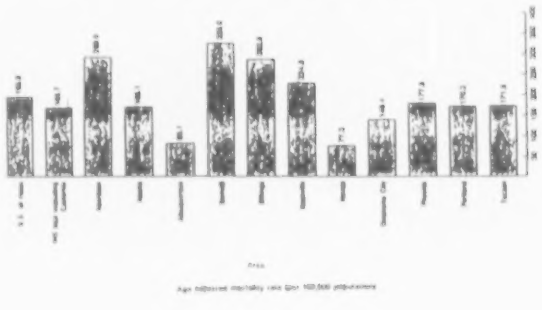
[g]Excludes "females with deliveries" (ICD-9-CM code V27), the rate for which is included in "complications of pregnancy."

[h]Totals may not add due to rounding.

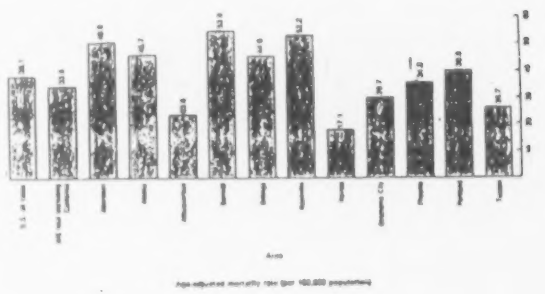
SOURCES: U.S. data: U.S. Department of Health and Human Services, Public Health Service, National Center for Health Statistics, *Advance Data From Vital and Health Statistics*, No. 112, DHHS Pub. No. 85-1250 (Hyattsville, MD: PHS, Sept. 27, 1985). IHS data: U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Indian Health Service, "Utilization of Indian Health Service and Contract Hospitals Fiscal Year 1984," internal document, no date, and U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Indian Health Service, Patient Care Statistics Staff, "Hospital Discharge Rate for Leading Causes," internal document, Feb. 11, 1985.

Figure 11

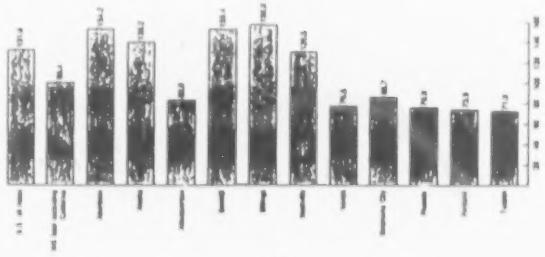
Age-Adjusted Death Rates for Diseases of the Heart, American Indians in 11 IHS Areas (excluding California) 1980-82



Age-Adjusted Death Rates for Cerebrovascular Disease, American Indians in 11 IHS Areas (excluding California) 1980-82



Age-Adjusted Death Rates for Malignant Neoplasms (Cancer), American Indians in 11 IHS Areas (excluding California) 1980-82



Age-Adjusted Death Rates for Pneumonia, American Indians in 11 IHS Areas (excluding California) 1980-82

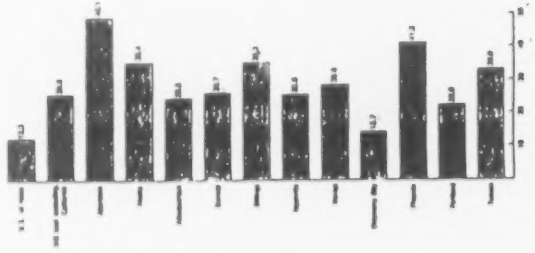
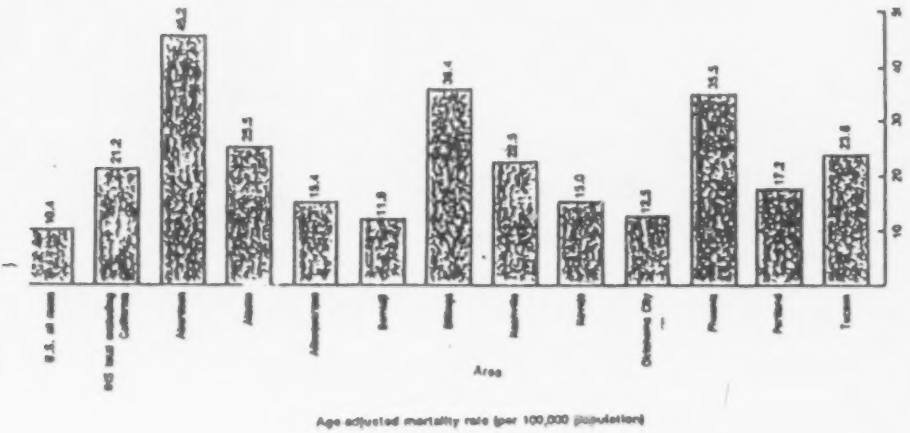


Figure 11 continued

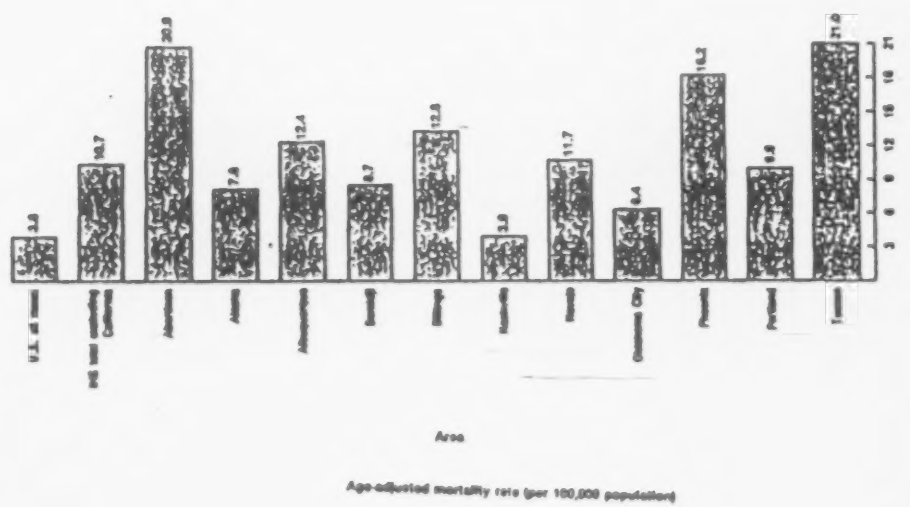
Age-Adjusted Death Rates for Diabetes Mellitus, American Indians
in 11 IHS Areas (excluding California) 1980-82



Area

Age adjusted mortality rate (per 100,000 population)

Age-Adjusted Death Rates for Renal Failure American Indians Both Sexes,
in 11 IHS Areas (excluding California) 1980-82



Area

Age-adjusted mortality rate (per 100,000 population)

problems. Thus, it is difficult to assess the adequacy of the IHS health care delivery system. Direct comparisons of health services systems for Indians and the U. S. population are particularly difficult. OTA's April 1986 assessment, and a follow-on staff paper on clinical staffing in IHS (U. S. Congress, OTA, February 1987) suggest several issues concerning the IHS system. These include: overall scarce resources, concentration on medical services, and uneven distribution of resources across areas.

Overall scarce resources

Spending for health services to Indians has just kept pace with inflation. Figures 12 and 13 indicate that, although there have been increases in IHS allocations, when adjusted for inflation, funding has been essentially flat since 1972. Although the comparison is far from exact (e.g., see USDHHS, PHS, HRSA, IHS, Task Force, June 1989a), one indicator of the discrepancy between IHS health service provision and that for the general population is that the 1987 per capita allocation for the IHS service population was $845, while per capita national health expenditures for 1988 was $1,987 (Letsch, Levit, & Waldo, 1988).[20]

Another indicator of disparities is the difference in availability of medical personnel to Indians. OTA's report on clinical staffing in the IHS found an average ratio of 0.7 physicians per 1,000 service population (table 4) (U. S. Congress, OTA, 1987). In comparison, the average ratio in

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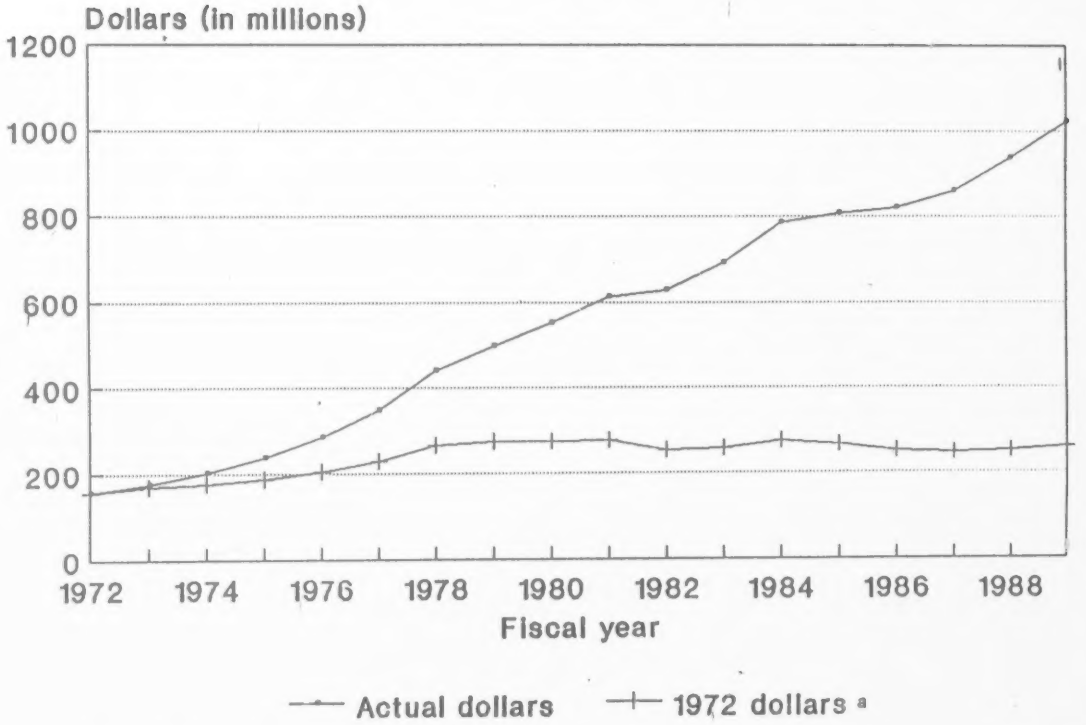
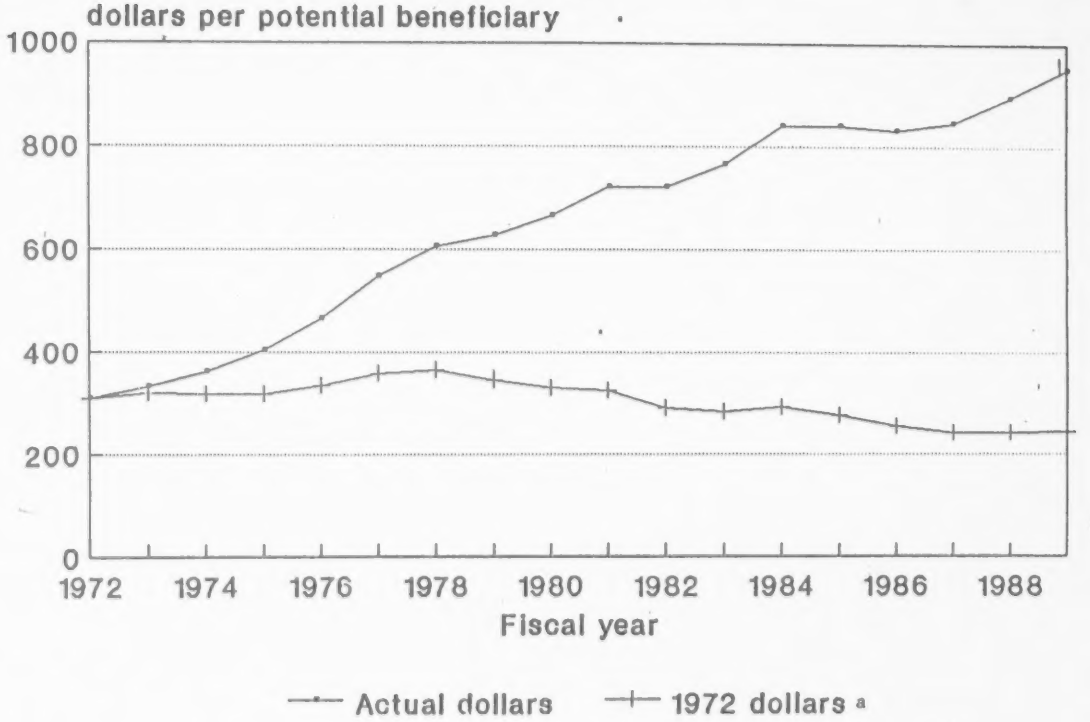
20 It is important to recognize the limitations of this comparison. The IHS per capita figure does not include any personal health spending by Indians in IHS service areas (that is, the independent use of Medicare, Medicaid, private health insurance, or a patient's own funds). The extent of such personal spending is unknown. On the other hand, while 86 percent of the IHS allocation figure is for clinical services, a small portion of it is for services such as sanitation, health education, and scholarships (see table 1), items which are not included in the national health expenditures figure (Letsch, et al., 1988).

Figure 12. - IHS Total Allocations, Fiscal Years 1972-89



[a] Consumer Price Index for medical care was used as a deflator.
SOURCE: Office of Technology Assessment

Figure 13. - IHS Allocations Per Potential Beneficiary, 1972-89



[a] Consumer Price Index for medical care was used as a deflator.
SOURCE: Office of Technology Assessment

Table 4. - IHS Medical and Dental Officers in Relation to Eligible Service Population by Area, Fiscal Year 1984[1]

Area	IHS eligible service population (1984)	Clinical		Service population ratios	
		Medical officers	Dental officers	Physicians per 1,000	Dentists per 1,000
Aberdeen	70,648	25	20	0.4	0.3
Alaska	71,329	98	35	1.4	0.5
Albuquerque	51,211	52	20	1.0	0.4
Bemidji[2]	47,000	18	13	0.4	0.3
Billings	40,106	40	17	1.0	0.4
California[2]	71,642	1	0	0.0	0.0
Nashville[2]	35,822	9	3	0.3	0.1
Navajo	162,005	145	42	0.9	0.3
Oklahoma	190,451	94	44	0.5	0.2
Phoenix	82,309	110	23	1.3	0.3
Portland[3]	96,427	25	17	0.3	0.2
Tucson	17,852	14	3	0.8	0.2
Headquarters	0	14	3	—	—
IHS total	936,802	645	240	0.7	0.3

[1]Forty-four medical officers and 29 dental officers serving in nonclinical capacities during fiscal year 1984 have been excluded from these calculations. IHS employees of tribal contractors assigned under IPAs and MOAs are included with IHS full-time, permanent staff. Staff hired directly by the contractors are not included.
[2]Total numbers of staff probably are low in these areas, because staff hired directly by tribal contractors are not included; consequently, service population ratios may be low.
[3]IHS staffing is somewhat low in the Portland area because there are no IHS hospitals there, and nearly half the budget is spent on contract care.

SOURCES: U.S. DHHS, PHS, HRSA, IHS, service population estimates from the population statistics staff; medical and dental officers in clinical practice from the Office of Indian Resources Liaison (unpublished data), 1985.

metropolitan areas of the United States was 1.91 physicians per 1000 population. Even in nonmetropolitan (rural) areas, to which Indian service areas are often compared, the physician to patient ratio was higher (0.84 physicians per 1000 population) than for the IHS. There is no national standard for physician staffing ratios, but one physician per 1,000 population is generally used as a rule of thumb (U. S. Congress, OTA, 1987).

While acknowledging the difficulty of calculating such a figure, an IHS Task Force on Parity estimated that it would take $950 million in fiscal year 1987 to raise IHS hospitalizations and medical and dental visits to the levels of the U. S. population (USDHHS, PHS, HRSA, IHS, June 1986a). This would have been $228 million greater than the President's budget request of $722 million for that year. Including pay costs and a supplemental appropriation, Congress appropriated $870 million for the Indian Health Service for fiscal year 1987. For fiscal years 1988 and 1989, the amounts were increased to $943 million and $1.02 billion, respectively. OTA is unable to assess currently whether these increased amounts have improved the health status of Indians and their access to services. By at least one internal IHS indicator, health services are still great. In fiscal year 1988, the first year in which the need was measured quantitatively, 28,775 contract services were reported to be deferred by area offices. According to IHS, these would have cost an estimated $33,087,468 to treat (Muri, personal communication, May 5, 1989).[22]

Concentration on medical services

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22 Deferred services are those contract health services which cannot be provided within existing contract care funds. Estimates of deferred services are inexact. In order to be eligible for the deferred services list, the patient has to have accessed the IHS system, and the care the patient requires has to be within the medical priorities of the area. Because areas have different contract care budgets, they may set different medical priorities (see U. S. Congress, OTA, 1986).

Despite the apparent great needs for dental, mental health, alcoholism, and preventive services, IHS, perhaps of necessity, continues to be primarily a provider of acute clinical care. As noted above, 86 percent of IHS's budget is used for clinical services; only 9 percent of this clinical budget is for dental, mental health, and alcoholism treatment combined. Only 7 percent of the total IHS budget is allocated to prevention activities.

The need for mental health and preventive services is well-recognized by Indian people and by IHS (U. S. Congress, OTA, 1986). The high homicide, suicide, and alcoholism death rates support his need, as do recent reports of widespread child abuse. Yet IHS's $13- to -$14 million[23] budget for mental health services in fiscal year 1988 would have provided only $12 per person for mental health services. Although hospitalizations for mental disorders should probably not be encouraged, it is interesting that hospitalizations for mental disorders in IHS direct and hospitals declined substantially between 1972 and 1984, while psychiatric hospitalizations in U. S. non-Federal short stay hospitals increased and then leveled off in the same period (figure 14).

Resources for mental health services seem unlikely to increase. The President's budget for fiscal year 1990 proposes decreasing the number of FTEs assigned to the direct care program for mental health by 25 (from 190 to 165), although a slight increase in dollars is suggested (from $10,197- to $10,567-million)[24] (USDHHS, PHS, IHS, 1989).

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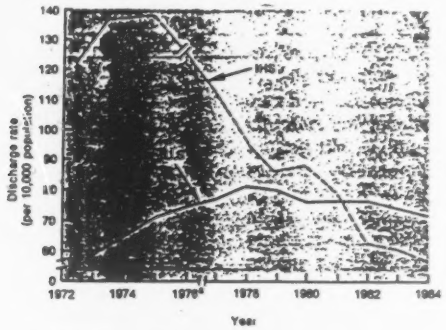
23 $13 million for direct services; approximately $1 million is spent in contract care funds for mental health.
24 When tribal activities are included, the adjusted appropriations for mental health are $13,091- and $13,582-million, respectively.

Figure 14. - Hospitalization for Mental Disorders IHS Direct and Contract Hospitals and U.S. Non-Federal Short-Stay Hospitals 1973-1984



[a]Missing data.

SOURCES: 1973-1983 IHS and 1974-1980 and 1982-83 U.S. data: IHS, Patient Statistics Branch, Hospital discharge rates, internal documents, January 15, 1974-Feb. 6, 1984; 1984 IHS data: U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Office of Planning, Evaluation and Legislation, Program Statistics Branch, Patient Care Statistics Staff, *Utilization of Indian Health Service and Contract Hospitals, Fiscal Year 1984*, Internal document, Rockville, MD: no date. 1981 U.S. data: U.S. Department of Health and Human Services, Public Health Service, National Center for Health Statistics, "Utilization of Short-Stay Hospitals: United States, 1981 Annual Summary," *Vital and Health Statistics*, Series 13, No. 72 DHHS Publication No. (PHS) 83-1733 (Hyattsville, MD: Public Health Service; August 1983). 1984 U.S. data: U.S. Department of Health and Human Services, Public Health Service, National Center for Health Statistics, *1984 Summary: National Hospital Discharge Survey, Advance Data from Vital and Health Statistics*, No. 112, DHHS Publication No. (PHS) 85-1250 (Hyattsville, MD: PHS, Sept. 27, 1985).

Likewise, the number of FTEs assigned to direct care dental services is slated for a decrease in the President's budget. OTA's analysis of dental services in IHS areas found an average of 70 percent "required but not provided" (table 5).

OTA's 1986 analysis of hospital utilization found lower hospital utilization than might be expected, given the poor health of the Indian people as reflected in mortality statistics and field reports. OTA found it striking that the overall 1984 hospital discharge rate in IHS areas (1,210 per 10,000 population) was 23.6 percent lower than that in U. S. non-Federal short-stay hospitals (1,585 discharges per 10,000 population) (see table 3).[25] Part of the variation seemed to be explained by the relative youth of the Indian population, but age-specific rates seemed lower among Indians too. However, OTA judged that, in part, inconsistencies might more accurately be traced to variations in services available to Indians in different areas because of differing reliance on contract care funds.[26]

Uneven distribution of resources across areas

In the course of its 1986 assessment, OTA found that:

> Most Indian tribes and all IHS area offices have opinions about the methods and results of IHS's approach to resource allocation: none of the areas is satisfied that it is receiving adequate resources. In part, this view reflects dissatisfaction with the overall level of

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25 IHS reports that the comparisons for 1988 were: IHS hospital discharge rate, 1,016 per 1000 population; U. S. rate, 1,382 per 1000 population, a difference of -26.5 percent ((USDHHS, PHS, IHS, February 21, 1989).
26 The Portland area, for example, has no IHS hospitals and must purchase hospital care through the contract care program. Contract care had been limited in past years to emergency and urgent cases. In the Portland area, the number of hospital discharges in 1984 (176 discharges) was almost identical to the number in 1979 (166 discharges), despite a 50-percent increase in the service population. As a result, the 1984 Portland area hospital discharge rate for most of the diagnostic categories was below what would have been expected from mortality data. The Bemidji and Nashville program areas also follow this pattern.

Table 5. - Dental Services Required in 12 IHS Areas

Area	Population	Services required[a]	Services provided[b]				Number of services required but not provided[c]	Percent required but not provided
			IHS	Contract	Tribe (638)	Total		
Aberdeen	70,648	500,188	104,490	17,706	25,555	147,751	352,437	70%
Alaska	71,329	505,009	103,249	23,481	67,093	193,823	311,186	62
Albuquerque	51,211	362,574	114,402	34,512	1,410	150,324	212,250	59
Bemidji	47,000	332,760	55,921	29,970	43,778	129,669	203,091	61
Billings	40,106	283,951	135,068	8,770	—	143,838	140,113	49
California	71,842	507,226	—	6,563	119,108	125,671	381,555	75
Nashville	35,822	253,620	33,843	12,956	42,380	89,179	164,441	65
Navajo	162,005	1,146,995	295,296	39,071	—	334,367	812,628	71
Oklahoma	190,451	1,348,393	267,704	42,597	11,874	322,175	1,026,218	76
Phoenix	82,309	582,748	136,430	8,769	2,327	149,853	432,895	74
Portland	96,427	682,703	89,448	50,075	15,477	155,000	527,703	77
Tucson	17,852	126,392	12,748	2,520	—	15,268	111,124	88
Area total	936,802	6,632,559	1,348,599	276,990	329,002	1,954,918	4,675,641	70%

[a]Equal to 11.8 units required × 60 percent of service population (IHS, "Findings from an Oral Health Survey of Native Americans," internal document, Rockville, MD, Jan. 31, 1985).
[b]Does not include services provided in urban programs, some of which may have been provided to IHS service area population.
[c]Equal to total services provided subtracted from services required.

SOURCE: U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Indian Health Service, Dental Services Branch, internal documents, Rockville, MD, various dates, 1985.

> IHS appropriations. In addition, however, there is a general belief that IHS is not allocating resources among its areas as equitably and cost-effectively as it could. These issues of equity, a rational basis for resource allocation, and the most cost-effective use of IHS's limited resources were debated at all of OTA's regional meetings (U.S. Congress, OTA, 1986, p. 228).

Comparisons of mortality rates by area, hospital utilization by area, budget allocations by area, and workload by area give substantial credence to the opinions of people in the field about the equitable allocation of resources across areas, although such comparisons can be risky. The differences in mortality rates and hospital utilization rates by area were discussed previously. Tables 6 and 7 show the differences in per capita allocations by area, and direct care workload by area, respectively. It is instructive, perhaps, that the Aberdeen area, which had the highest mortality rate of all IHS areas in 1980-82, ranked seventh in per capita resource allocation in 1985 (table 6), and first in workload (table 7). Comparisons across areas should probably not be used, however, to infer that some areas have too many resources. Even though their relative rankings may suggest that they are receiving "more than their share" the previous discussion of health status should indicate that no Indian area has achieved parity with the general population in all health categories.

OTA found that the basis for resource allocation among IHS areas was basically historical. That is, IHS has traditionally distributed its annual appropriations among its areas by budget category, according to each area's share of the budget from the previous year.[27] This method did not take unmet health needs into account. IHS has attempted over the years to make the distribution of resources more equitable. The latest method

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27 In addition, Congress occasionally earmarks funds for certain projects.

Table 6. - IHS Budget Allocations by Area
With Estimated Per Capita Allocations, Fiscal Year 1985

IHS area	Fiscal year 1985 allocation	1985 IHS service population		1985 IHS user population	
		Population estimate[a]	Per capita allocation	Population estimate[b]	Per capita allocation
Aberdeen	$ 74,270,100	72,679	$1,021.89	72,679[a]	$1,021.89
Alaska	119,792,600	73,351	1,633.14	73,351[a]	1,633.14
Albuquerque	53,365,300	52,471	1,017.04	51,363[c]	1,038.98
Bemidji	39,332,100	48,245	815.26	44,337[c]	887.12
Billings	51,495,000	41,326	1,246.07	38,470[c d]	1,338.58
California	31,243,300	73,414	425.58	26,640[e]	1,172.80
Nashville	32,421,600	36,413	890.39	28,696[f]	1,129.83
Navajo	106,834,600	166,493	641.68	166,493[a]	641.68
Oklahoma	98,540,400	195,346	504.44	178,456[c]	552.18
Phoenix	88,369,600	84,516	1,045.80	79,502[c]	1,111.54
Portland	49,198,500	98,996	496.97	62,380[f]	788.69
Tucson	17,796,000	18,332	970.76	15,959[c g]	1,115.11
IHS area totals	$762,659,100[h]	961,582	$ 793.13	838,326	$ 909.74

[a]IHS census-based eligible service population estimates, 1985. When estimated user population counts from other sources exceeded census-based estimates, IHS Office of Program Statistics elected to use the census-based estimates (fourth column).
[b]Fiscal year 1985 population estimates developed by IHS Office of Program Statistics, recommended for use in fiscal year 1986 allocation.
[c]Estimate modified by special computer routine to remove duplicates from ambulatory patient care records.
[d]Based on contract workload data.
[e]Based on special count of users from individual California tribal projects.
[f]Based on IHS area office user count data.
[g]Includes enrollment in Pascua-Yaqui health maintenance organization.
[h]This sum of IHS area allocations in fiscal year 1985 (final as of 9/26/85) excludes funding for IHS headquarters functions in Rockville, MD, and Albuquerque, NM.

SOURCE: U.S. Congress, Office of Technology Assessment, based on data from U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Indian Health Service, Office of Program Statistics, Resources Management and Program Statistics Branches, 1985.

Table 7. - IHS Area Comparison of IHS Direct Care Workload by Clinical Units, Fiscal Year 1984[1]

Area	1984 service population	(i) Clinic outpatient visits	(ii) Hospital outpatient visits	(iii) Hospital days: Adults and peds.	(iv) Hospital days: Newborns	(v) Clinical units	(vi) Total staff	(vii) Clinical staff	(viii) Clinical units per staff	(ix) Clinical units per clinical staff
Aberdeen	70,648	116,660	205,104	44,612	2,654	115,893	915	476	127	243
Alaska	71,329	64,508	197,672	68,084	4,348	116,162	1,260	600	92	194
Albuquerque.....	51,211	108,754	162,900	27,467	1,485	74,228	918	486	81	152
Bemidji	47,000	47,037	62,349	5,380	242	23,853	270	146	88	163
Billings	40,106	169,519	100,866	11,619	800	57,683	616	292	94	198
California	71,642	86,440[2]	NA	NA	NA	0	81	5	—	—
Nashville.....	35,822	4,563	58,338	6,329	199	18,678	189	105	88	159
Navajo	162,005	[illegible]	462,894	66,813	9,881	194,394	2,033	1,191	96	163
Oklahoma	190,451	254,337	312,[illegible]	49,653	7,830	151,879	1,805	921	95	165
Phoenix	82,309	94,510	295,[illegible]	80,439	3,436	148,842	1,546	795	96	187
Portland	96,427	212,547	NA	NA	NA	35,425	388	184	91	193
Tucson	17,852	22,388	36,616	7,316	184	17,333	154	85	113	204
Headquarters	0	NA	NA	NA	NA	0	387	72	—	—
IHS total	936,802	1,206,128	1,982,264	389,911	31,059	952,369	10,342	5,360	92	178

[1]Utilization figures in this table represent IHS direct care workloads. Outpatient visits to tribally operated programs and urban projects, and contract care program utilization, are not included. Columns (i) through (iv) include IHS facilities only; column (v) assumes 6 outpatient visits equal 1 hospital day; and columns (vi) and (vii) include Federal employees assigned to tribal contractors under IPAs and MOAs. Staff hired directly by the contractors are not included.

[2]Provisional data from the California Program Office, "Workload Statistical Summary," calendar year 1984.

SOURCES: U.S. DHHS, PHS, HRSA, IHS, service population estimates from the population statistics staff; outpatient visits and hospital days from the patient care statistics staff; total staff and clinical staff from the Office of Indian Resources Liaison (unpublished data), 1985.

explicitly uses differential health status and additional potential users as part of the formula[28] (USDHHS, PHS, IHS, OPEL, Division of Health Services Planning and Operations Research, April 1988). However, this resource allocation methodology (RAM) depends primarily on the existence of sufficient new resources, and remains incremental.[29,30] In fiscal year 1989, IHS judged that there were insufficient funds in the hospitals and clinics budget to redistribute moneys based on the RAM methodology, although some funds will be redistributed within the contract health services budget (Wiggins, personal communication, 1989). However, it seems encouraging that, should sufficient resources become available, the precedent of taking health status explicitly into account when distributing resources has been set.[31]

Conclusion

In conclusion, OTA found the Federal health care delivery system for Indians to be an extremely complicated system, in which scarce resources were being used to provide a variety of types of health care to a

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28 A health status index, as measured by years of potential life lost, accounts for 30 percent of the formula; a population index accounts for 10 percent of the formula.

29 According to the RAM manual,

> In any given year, if sufficient new resources are appropriate then portions of such resources will be designated for the RAM fund and be distributed to areas by RAM. If appropriations remain approximately the same, then IHS may designate a percentage of the program base budget for the RAM fund. The amount of existing base resources designated for the RAM fund will depend upon other new resources..., the degree of remaining funding disparities, and directives or guidance from the Congress, the OMB, and DHHS. However, the amount of base distribution in a year will be small..." (USDHHS, PHS, IHS, OPEL, Division, April 1988).

30 In fiscal year 1988, areas received approximately an average of 2- to 3- percent of their increases in funding as a result of the RAM methodology. Only $3.5 million of these increases came within the direct care clinical allocation (USDHHS, PHS, IHS, OPEL, Division of Health Services Planning and Operations Research, April 1988); another $9.9 million was redistributed within the contract health services allocation.

31 OTA has not, however, made a detailed review of the RAM methodology.

geographically scattered, typically poor and unhealthy population. Of necessity, IHS emphasizes acute medical care, and is often unable to provide adequate amounts of that. Oftentimes, the goals of the IHS may conflict with each other (e.g., to provide coordinated health care and to allow tribal programs to be entirely self-governed).

Given the scarce resources available to IHS to achieve its mission, OTA cannot conclude that the inadequacies in the IHS system can be held entirely responsible for the continuing poor health of Indian. There may be adjustments, however, that could help to improve the delivery of health services to Indians, and, perhaps, their health. Certainly more resources, more equitably distributed among areas, would help. Greater attention to preventive, dental, mental health, and alcoholism services seems warranted. Not all issues pertaining to Indian health services could be addressed in this testimony, and I respectfully refer the Committee to the Indian Health Care report and special report on clinical staffing for in-depth discussions of additional matters.

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Figure 1

Indian Health Service
DHHS/PHS

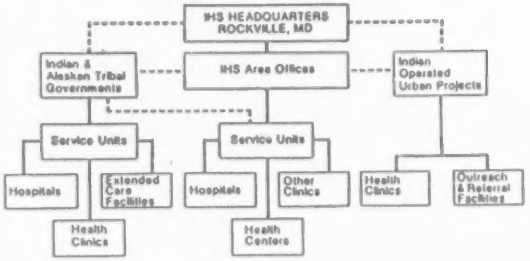


Figure 3

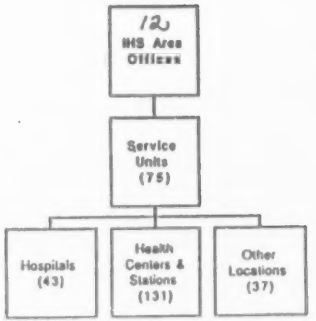


Figure 2

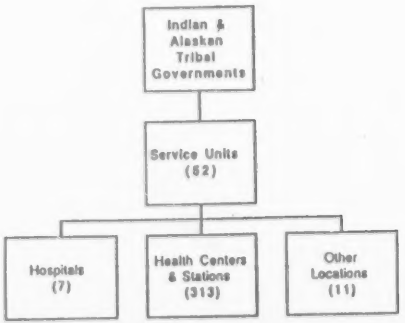


Figure 4

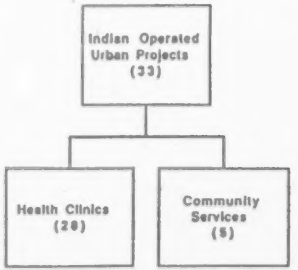
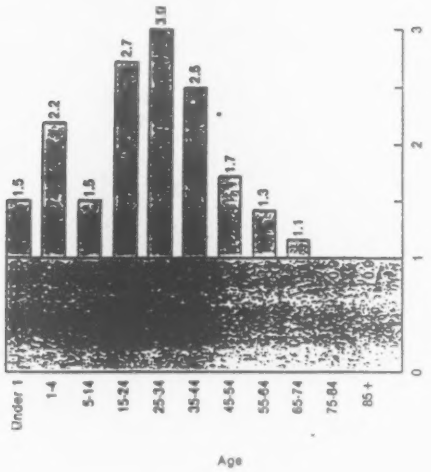
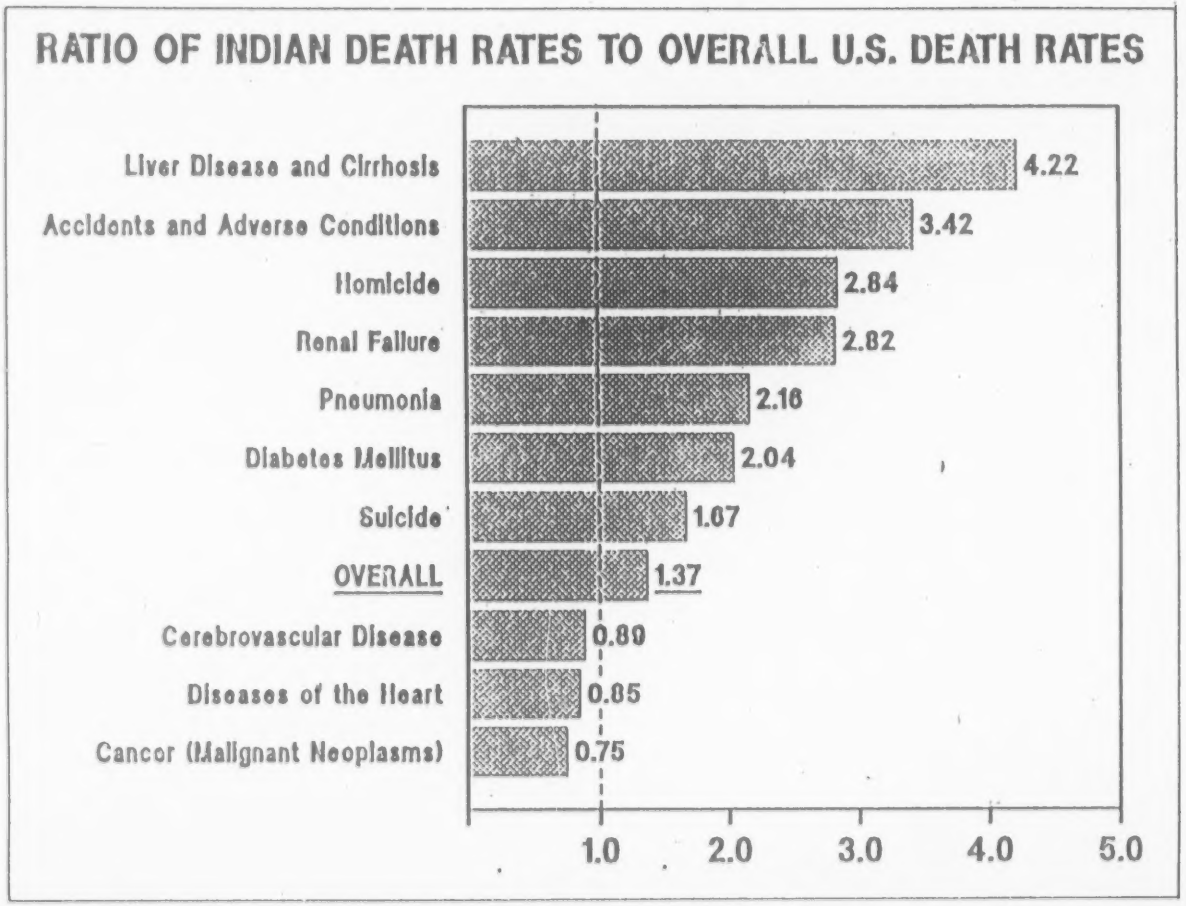


Figure 8. - Age-Specific Mortality Rates Ratio of Indians in IHS Service Areas 1980-82 to U.S. All Races 1981



SOURCE: U.S. Department of Health and Human Service, Indian Health Service, Office of Administration and Management, 1985.


RATIO OF INDIAN DEATH RATES TO OVERALL U.S. DEATH RATES
Liver Disease and Cirrhosis
Accidents and Adverse Conditions
Homicide
Renal Failure
Pneumonia
Diabetes Mellitus
Suicide
OVERALL
Cerebrovascular Disease
Diseases of the Heart
Cancer (Malignant Neoplasms)
4.22
3.42
2.84
2.82
2.16
2.04
1.67
1.37
0.89
0.85
0.75
1.0
2.0
3.0
4.0
5.0

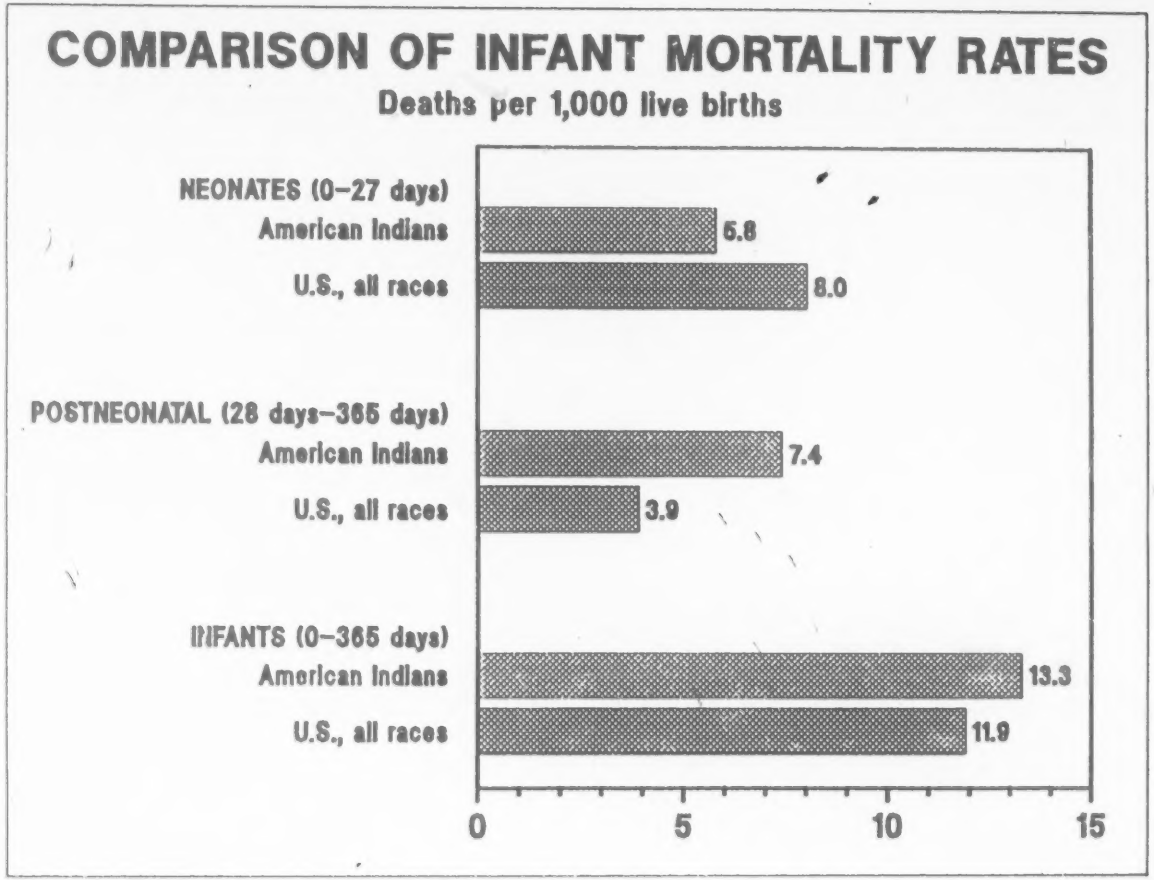
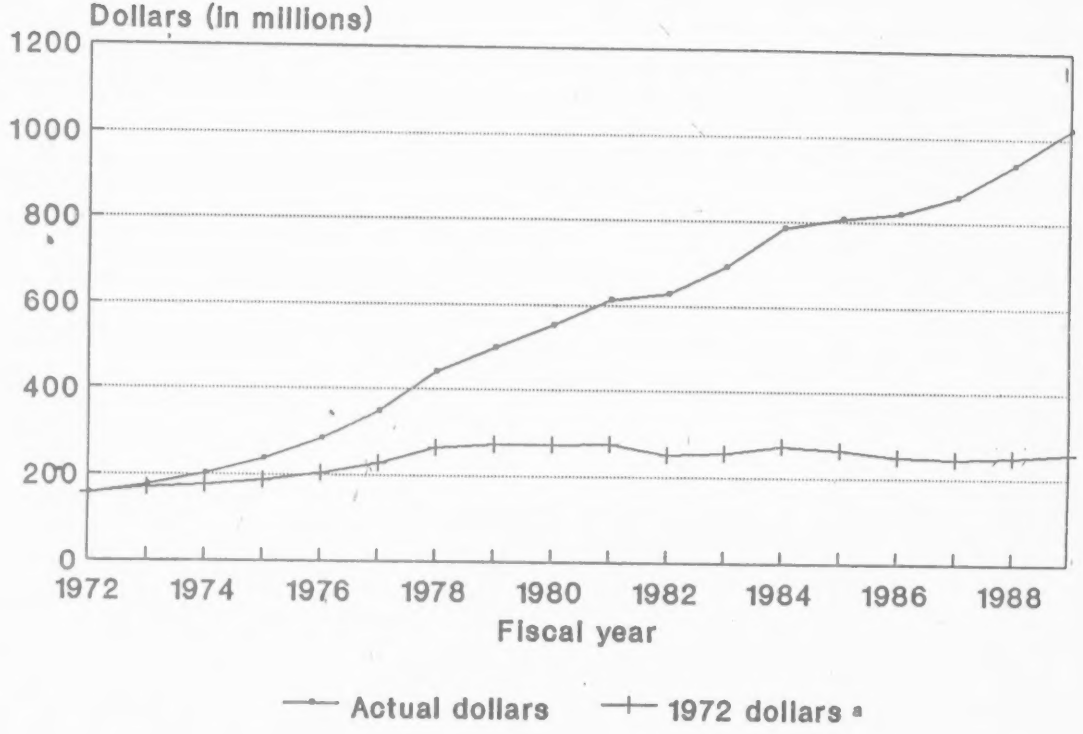
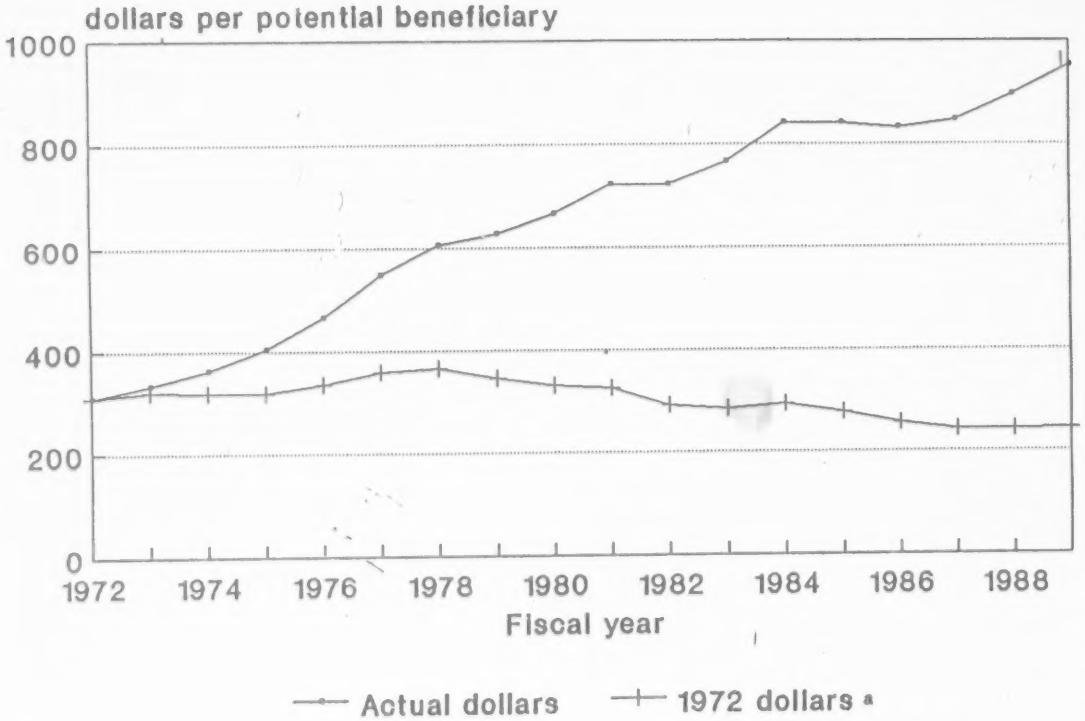

COMPARISON OF INFANT MORTALITY RATES
Deaths per 1,000 live births
NEONATES (0–27 days)
American Indians
5.6
U.S., all races
8.0
POSTNEONATAL (28 days–365 days)
American Indians
7.4
U.S., all races
3.9
INFANTS (0–365 days)
American Indians
13.3
U.S., all races
11.9
0
5
10
15

Figure 12. - IHS Total Allocations, Fiscal Years 1972-89



[a] Consumer Price Index for medical care was used as a deflator.
SOURCE: Office of Technology Assessment

Figure 13. - IHS Allocations Per Potential Beneficiary, 1972-89



a Consumer Price Index for medical care was used as a deflator.

SOURCE: Office of Technology Assessment

Dr. Bruce Nicholson's Testimony

Good morning Mr. Chairman, Sen. McCain and Sen. Daschle. I am honored to appear before you this morning to discuss my experience with the Indian Health Service and to suggest possible solutions. The Indian Health Service has a serious and vital mission to perform and I only hope that my testimony here will help them in some small way to remain focused on why it is they are in operation -- to serve the Indian people.

I would first like to discuss the conditions that we health professionals must deal with at Indian Health Service facilities. The buildings themselves are often in need of repair and often the medical equipment is outdated. The biggest problem, however, is the constant lack of adequate staffing. Physician and nursing shortages are far too frequent. the proper numbers of ancillary staff (such as lab technicians or x-ray technicians) are rarely adequate. The ancillary personnel seem to be affected most by the low wages that are offered as well as the lack of job security. As for physicians and nurses, they are most affected by high rates of "burnout" caused by the magnitude of the task that confronts them.

These factors lead to physician/patient ratios that are unheard of in the rest of the country. At Pine Ridge, this ratio was often one physician for every 2,000 patients. Not only are the facilities under-staffed and poorly equipped, but the types and frequency of disease are overwhelming. The extreme poverty on the Pine Ridge reservation leads to more complicated illnesses, such as uncontrolled diabetes, and inordinate numbers

of infectious disease coupled with high rates of alcoholism. Alcoholism, in turn, results in domestic violence, child abuse, high rates of teenage pregnancy, high infant mortality rates, and uncontrollable suicide attempts. In general, the life expectancy for Native Americans is severely shortened by poverty and the diseases that come with it.

These are the types of problems that one tries to prepare for when one takes an IHS job. What is most disturbing, however, is the fact that IHS management, or I should say mismanagement, serves to compound these problems. A physician in the field looks to the administrators for support and assistance especially in situations as difficult as a reservation hospital. In my experience with the IHS, the support and assistance needed was seldom there. Above the service unit level, there did not seem to be credibility or consistency in IHS policy. One of the major areas of concern is financial mismanagement and credibility.

The Area office seemed incapable of properly projecting our operating budget, most of the time they never even came close. Budget projections can vary as much as $750,000 from one month to the next. In 1987, Pine Ridge suffered from a $1 million dollar deficit that was not projected. This lack of insight resulted in the layoffs of 70 local Pine Ridge employees.

Discussions at the service unit level often center on the incompetence of Area office personnel. The area is charged with prioritizing health problems in order to target money more efficiently. In my experience, they were spending money on

conferences and air travel when we were desperately asking for more nurse midwives and Ob-Gyn services to combat infant mortality rates of 30-40 per 1000 live births. After being at Pine Ridge, it is difficult to imagine that the figures IHS releases on infant morality are true. It is my understanding that up to $3 million dollars was lost because the incompetence of financial management personnel meant that many services went unbilled.

Finally, I believe the IHS suffers from a bureaucracy that has gotten out of control. There seems to be a redundancy in the positions that are spread throughout the system. I realize that all these problems may not be solvable, but I feel that if I am going to criticize the system then I must also try to propose some solutions. First, I believe that the bureaucracy needs to be reorganized and should be structured more like the system used in the Veteran's Administration (VA) which would eliminate the need for Area Offices. Second, I believe that the Commission Corps should also be eliminated and again this would be in line with the VA system. Third, the IHS needs to place more emphasis on hiring, and promoting qualified individuals. Lastly, I believe that there needs to be more funding for training programs and basic education for Native Americans so that they can control their own destiny in the health care field.

Thank you very much for your time and attention to this vitally important issue.

TESTIMONY OF JOHN GOBERT

Good morning Mr. Chairman and distinguished members of this Committee. I am very pleased to be able to appear before you this morning in order to give you my view on the operations of the Indian Health Service.

I have been with the IHS since 1969 serving mostly in the Aberdeen Area. I became a Service Unit Director in 1978 at the Newtown Service Unit and since then I have been a Service Unit Director at five other locations, four in the Aberdeen Area and the fifth, my current position, as Colville Service Unit Director in Nespelem, Washington. I have received numerous awards during my tenure including a Superior Work Performance Award, Administrative Employee of the Year and an Outstanding Work Performance plaque. I am a Board Certified Physician's Assistant which gives me the medical knowledge that is needed when making important funding decisions that will affect the provision of health care. I have also received extensive training in administrative management from both the Central Arizona College and the University of South Dakota. I consider myself a good manager who is able to accomplish difficult tasks.

I am here this morning to talk about (1) how administrative problems in the Aberdeen Area effect Native American health care, and (2) the severe manpower shortage problems that plaque the Aberdeen Area.

21-391 0 - 89 - 4

The Aberdeen Area suffers from poor management. One of the biggest problems is that the Area Office is unable to communicate effectively with the service units. In my personal opinion, there are people in key positions who are not fully qualified for their jobs. The result of all this has been Aberdeen's violation of the Anti-Deficiency Spending Act. While I was a Service Unit Director, we would be told that we could go ahead and purchase some service or equipment and we would do so, but when we sent the paperwork to the Area Office for payment they would deobligate the funds and use them for other purposes. We were left holding the bag and often needed services would be half finished or not finished at all. This is an example of how poor management translates into frustration for the Service Units.

This poor management eventually had a negative effect on the quality care that was being given. One example of this is physician recruitment and retention. Many doctors became frustrated with what was viewed as unresponsiveness by the Area Office which added to their feelings of burnout. The Area office would continue to hire administrative personnel while many facilities were going understaffed. Physicians would often complain about the lack of input they had on funding decisions.

The result of all this was that the Service Units had to struggle to find doctors so that they could keep their doors open. At one point, we turned to a temporary physicians' service called "Project USA." The IHS has an Area-wide contract with

this placement service. Unfortunately, the IHS began to use this service in place of their own recruitment personnel, and "Project USA" could not handle the volume of recruitment needed. In my estimation, the background checks that were performed on these individuals were inadequate. We became a testing ground for a large number of medically incompetent doctors. Several of the doctors that passed through my Service Unit were so inept that we did not allow them to practice and sent them back where they came from. The whole system was hit or miss.

Another point that I would like to make about the Aberdeen Area is that they were very inconsistent in their policy making. Before I left, we were told that we would have to cut 20 positions from our Service Unit. The other Service Units were told the same thing. The Area Office took no cuts in their own staff.

The bottom line is that I would like nothing better than to return to the Aberdeen Area. I am dedicated to the IHS and its mission but Aberdeen Area management drove me out and will keep me out until changes are made. As for now, I will have to sit back and watch to see if IHS Headquarters will take the necessary actions to make the much needed improvements in the Aberdeen Area.

Thank you very much.

TESTIMONY

by

Georgia Perez
Nambe Pueblo, New Mexico

Good afternoon. Thank you for allowing me to come before you. My name is Georgia Perez, the Community Health Representative for Nambe Pueblo and currently the chairperson for the Santa Fe Service Unit Indian Health Board. I've been a Community Health Representative generalist for 13 years and provide a wide range of health care services to the community of around 630 people. Services range from providing home visits to do health assessments, finding medical problems and make the necessary referrals for medical treatment, provide home health care, first aid treatment, provide transportation to medical appointments, do counseling and provide interpretation for the elderly regarding medical care and treatment. These are just a few of the many activities that I perform on a daily basis as the CHR. Another aspect of the program is the health education activities that are provided to the community. These activities cover health concerns such as diabetes, hypertension, environmental health concerns, wellness and many more. Many activities are carried out in group settings and by way of a monthly newsletter that the program provides to the community.

As a consumer advocate for the tribe, I serve as the representative to the Santa Fe Indian Health Board and as stated above, currently the chairperson. I have been on the health board for 13 years.

Let me give you a short introduction to our service unit. The Indian Health Service is a division of the U.S. Public Health Service, and the Department of Health and Human Services. The Santa Fe Service Unit is part of the

Albuquerque Area Office, which is one of 11 Indian Health Service regional offices. There are 27 tribes in the Albuquerque Area. The Santa Fe Service Unit serves 12 tribes (44% of all the Area tribes) with a population based on:

U.S. Census	14,564
Tribal Census	17,369
Patient Registration IHS	17,909
Patient Registration Facility	30,000 (unduplicated Medical Records)

The Santa Fe Service Unit comprises the following: Facility and Staff

The facility was built in 1978, is 75,000 square feet, is an Acute General Medical/Surgical facility with 43 beds[1] - offering the following services: General Medical, Pediatrics, Level II Obstetrics, Gynecology, General Surgery, 24 hour Emergency, Level II Intensive Care Unit:

General Medical/Surgical Beds	37
Obstetrics Beds	6
ICU/Recovery Beds	4/3

Statistics in 1988:

Outpatient	82,187 (25.5% of AAO)
Inpatient Admissions	2,019 (37.5% of Alb. Area Hospital Adm.)
Births	366 (70% all Births in AAO)
Inpatient Days	10,576 (40.3% of AAO)

Permanent Employees:

Hospital	203	Dulce	16
Taos	10	Santa Clara	14
Santo Domingo	1	San Felipe	1
Cochiti	0		

[1] Approved by Congress for 55 beds, but funded for 43 beds.

Temporary Employees:

Hospital	31	- Dulce	4
Toas	3	Santa Clara	2
Santo Domingo	0	San Felipe	0
Cochiti	0		

The Santa Fe Service Unit Budget/Hospital Clinic $7,861,148[2]

Projected Deficit $777,028 Contract Health Service budget $2.3 million

Projected deficit $165,000 (CHS)

These are the action steps that Santa Fe Service Unit is proposing to take because of the projected deficits:

1. The Santa Fe Service Unit effective 6/4/89 will reduce all Temporaries to 32 hours per week (40 Positions)
2. Alternative plan if deficit cannot be resolved is to 100% lay-off all Temporary positions.
3. If Contract Health Services are exhausted, legitimate health expenditure will be terminated.[3]

The Contract Health Services Budget for the Santa Fe Service Unit is always inadequate for even accepted high priority healthcare needs. We are projecting a $165,000 deficit for FY89 with four and one-half months yet to go and possible occurence of catastrophic illness.

As a consumer advocate and representing the Santa Fe Service Unit Indian Health Board, we support the efforts and funding of the Santa Fe Service Unit - and having this service available to the Indian people. As we have become dependent on this vital health care service; first for - Preventive Health, ongoing medical, to life-threatening medical care, and second for - our peoples employment. This

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2 See attachment 1

3 See attachment 2

resource is so much a part of my people's lives, I have devoted my professional and private life to working in it and trying to understand the whys. I know that the United States Government is facing a significant deficit. I understand that the Gramm-Rudman-Hollings Bill is a U.S. Government Policy to address this deficit issue. But people's health needs do not follow policy guidelines. Our present deficit will mean stoppage of services and reduction in employment. I want to present a few of my concerns:

For the Jicarilla Apache Tribe:

Rates of adolescent suicide among the Jicarilla Apache Indians are extremely high. These rates (both attempts and completions) are symptoms of a gradually eroding Indian community that is plagued by social, cultural, and economic problems. These high rates correspond also to the gradual disintegration of Indian family life in Dulce. It is estimated that as many as 10% of Dulce adolescents between the ages 15-19 have made a suicide attempt in the last one and a half years (January 1988 through May 1989).

The Dulce adolescent suicide attempt rate is almost 15 times the national average; Dulce's adolescent suicide attempt rate is also five times as high when comparing all other New Mexico Indians. The ratio of Dulce adolescent suicide attempts to completions is one and half times that reported for any other Native American population suggesting that younger age groups affected by suicide attempts are more than any other Indian community nationally (a ratio of 26:1 versus a ratio of 17.5:1). Eleven suicides were recorded for Dulce between 1983-1988 (6 years). Five of these suicides were under the age of 24. This rate is seven times the current national average.[4]

Moreover, the Dulce is the most remote satellite of the Santa Fe Service Unit, 130 miles from Santa Fe and 90 miles from the nearest hospital. This clinic serves 2,500 Jicarilla Apaches 24 hours a day, seven days a week, yet is staffed with only

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[4] See attachment 3

17 permanent and 4 temporary employees. The temporary positions are susceptible to the availability of funds and are having hours cut this year due to budgetary shortfalls. The main clinic building is 25 years old and ancillary services are provided in several dilapidated single-wide trailers which meet neither life safety, nor handicapped access codes. The main building is too small and the physical layout is inefficient. According to Indian Health Service planning parameters, the Facility is one-fourth the size and the staffing is less than one-half that required to serve this population. The extreme isolation and inadequate staff and facilities are barriers to recruiting and retaining critically needed professional staff, especially physicians. Dulce is among the most difficult physician recruitment locations in the IHS. In addition, although Congress has appropriated $550,000 to construct four new quarters in Dulce, the IHS refusing to begin construction further compounding difficulties in physician recruitment. Instead, the IHS is considering moving more old trailers from the Zuni reservation to serve as staff quarters. Trailers withstand the severe winters in Dulce very poorly and will only serve as another disincentive for professional staff considering positions available at this remote location.

Taos/Picuris Pueblo:

The Taos Indian Health Center, a geographically isolated facility located 75 miles north of Santa Fe, is an extreme example of a totally inadequate health care system. The current health care, constructed of adobe in 1928, has major non-repairable structural failures, is extremely overcrowded, and presents numerous patient and employee safety hazards. The current staff of 11 employees represents only 32% of the staffing levels required by Indian Health Service guidelines. Medical equipment has not been purchases for the past five years and consists primarily of items accessed by other medical programs. A new facility which has been approved by Congress would alleviate not only in structural concerns but would also allow

for adequate staff and equipment to serve the Taos and Picuris people. The Taos tribe recognizing the desperate need for a new facility has agreed to build and lease back the new structure to the Indian Health Service. The inability of Indian Health Service Headquarters to quickly initiate the lease back agreement is one of great concern to the Taos tribal leaders.

Three Southern Clinics:

The health services for the communities of Santo Domingo, San Felipe, and Cochiti are seriously limited by old, small, and inadequately equipped clinics that operate part-time in these three communities. Despite a population of 7,600 people, a high birth rate and increasing elderly population, we are unable to adequately serve the health needs out of clinics with limited space, no laboratory or x-ray, no pharmacist, and part-time staff.

Public Health Nursing:

Because of an Area wide deficit in the Public Health Nursing budget line item, the Santa Fe Service Unit has been imposed a hiring freeze of filling three (3) vacant public health nursing positions that provide vital follow-up medical care and services to the four communities north of Santa Fe which are Nambe, Tesuque, Pojoaque, and San Ildefonso Pueblos, one position for Cochiti Pueblo and one position for Santo Domingo Pueblo. An impact statement of reduction of services that will be provided to the communities states exactly how it will be felt.[5]

Equipment:

The Santa Fe Service Unit was built in 1978. The new equipment was valued at $4,568,600. This equipment is 11 years old (equipment life is 10 years). The aging equipment has caused the following:

1. More frequent break-down as equipment gets older.
2. Older model equipment, no longer made.
3. Equipment beyond repair.
4. Companies no longer around that made equipment(out of business).

[5] See attachment 4

Every year, the Service Unit submits priority equipment list to Area for consideration if funds are available. In FY88, no equipment purchased. In FY89, priority list is again submitted - again no funds available.[6] With no funds available for replacement or purchase of new equipment, I site the following:

In Surgery, equipment is breaking down. Defective and out of date, with no funds to replace. Examples are: an orthopedic drill used for intra-abdominal surgery, and an oximeter for measuring blood oxygen saturations. With no drill, fractured cases must be sent to outside hospitals. Three such cases would buy a new drill ($5,000). It is too bad when we have the staff and facility, but lack simple equipment to do the job. Why is there no line item budget for equipment? The lack of such forces us to either go without or use funds intended for salaries and other necessities.

Needs of the Elderly and the Alcoholics:

The Santa Fe Service Unit addresses the acute-medical care needs of the people but are not adequately funded to address the problems of the chronically ill patient and the complex problems of the alcoholic patient. There is a need for the Albuquerque Area and the Service Units to address these needs, but until they are adequately funded, health care problems for these two groups will continually be unaddressed. There is a need for an extended care facility for rehabilitative purposes for the alcoholic patient and an intermediate care facility for our elderly population.[7]

FEDERAL AGENCIES:

Why, does one government agency impose funding regulation and another (U.S. Civil Service Commission)[8] issue mandatory personnel payments with no additional funds. It seems inconsistant that a system that is indicating a deficit is required to go further into debt, especially when the Anti-Deficiency

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6 See Attachment 5

7 See Attachment 6

8 See Attachment 7

Act prohibits federal officials from deficit spending.

SUMMARY:

In summary, the deficit means no services to the Indian people, reduction in personnel, while utilization continues to increase and the patients will have to absorb this enormous financial burden. I thank you for this opportunity to discuss a few of my concerns which I categorized as short-term; but Gramm-Rudman-Hollings and the Federal Deficit are long-term. You, the Legislative Body and we, the American Indians must work together to resolve, what I feel is a major crisis in the future.

Attachment List

ATTACHMENT 1 - Santa Fe Service Unit Budget

ATTACHMENT 2 - Copy of letter from one service unit regarding depletion of Contract Health Service Funds with reduction of medical care services.

ATTACHMENT 3 - Statistical data of Dulce Adolescent Suicides

ATTACHMENT 4 - Impact Statement of Public Health Nursing services to the communities

ATTACHMENT 5 - Equipment List needs

ATTACHMENT 6 - Elderly & Chronic illness impact report and needs

ATTACHMENT 7 - Memorandum for mandatory personnel payments

ATTACHMENT 1

ALBUQUERQUE AREA INDIAN HEALTH SERVICE

PREPARED BY:
AAO/BUDGET
04/17/99

STATEMENT OF PROJECTED FINANCIAL POSITION

FOR THE PERIOD OCTOBER 1, 1998 THROUGH SEPTEMBER 30, 1999

LOCATION: SANTA FE SERVICE UNIT HOSPITALS & CLINICS

AS OF MARCH 31, 1999

OBJECT CLASS	YEAR TO DATE ALLOWANCE	YEAR TO DATE CUMULATIVE OBLIGATIONS	YEAR TO DATE FUND BALANCE	ANNUAL ALLOWANCE	ANNUAL PROJECTED OBLIGATIONS	YEAREND PROJECTED FUND BALANCE
11.00 PERSONNEL COMPENSATION	$2,699,129	$2,713,797	($14,669)	$3,390,257	$3,473,084	($74,827)
12.00 PERSONNEL BENEFITS	589,721	619,711	($15,991)	1,907,441	1,952,589	($45,148)
12.19 RETENTION/CONTINUATION PAY	48,000	48,000	0	135,000	135,000	0
21.00 TRAVEL & TRANSP. OF PERSONS	17,000	34,631	($6,748)	35,776	49,262	($13,486)
22.00 TRANSPORTATION OF THINGS	43,942	73,725	($29,783)	87,884	147,431	($59,547)
23.00 RENTS, COMMU. & UTILITIES	339,721	391,687	($50,966)	661,642	783,379	($121,737)
24.00 PRINTING & REPRODUCTION	1,045	1,090	($45)	2,099	2,180	($90)
25.00 OTHER SERVICES	38,073	30,027	8,046	116,150	100,033	16,097
25.00 TRIBAL SERVICES	0	9,521	($9,521)	0	9,521	($9,521)
26.00 SUPPLIES & MATERIALS	300,554	542,549	($233,995)	617,188	1,085,999	($467,991)
31.00 EQUIPMENT	0	0	0	0	0	0
OTHER OBJECT CLASSES	0	644	($644)	0	644	($644)
TOTAL SANTA FE SERVICE UNIT	$3,911,674	$4,275,382	($364,008)	$7,961,148	$8,638,176	($677,028)

NOTE: THE "YEAR TO DATE ALLOWANCE" AND THE "ANNUAL ALLOWANCE" INCLUDES UNDER OBJECT CLASS 12.19 THE REIMBURSABLE RETENTION/SPECIAL PAY NON-RECURRING ALLOWANCE. THE NON-RECURRING ALLOWANCE WAS INCLUDED IN ORDER TO OFFSET THE APPROPRIATE OBLIGATION AND ITS PROJECTION.

ATTACHMENT 2

...ice
...n Hospital
...Tower Drive NE
Albuquerque, New Mexico 87108

SUD-89-65

Honorable Joe L. Loretto
Pueblo of Jemez
P. O. Box 78
Jemez, NM 87024

Dear Governor Loretto:

This letter is to alert you and the tribal council that the Albuquerque Service Unit will deplete its contract health services allocation of $3,245,906.00 by the fourth week in July of this year. At this time the Service Unit provides contract health services for 9000 pueblo tribes and a significant other 9000 urban tribal members who reside in Bernalillo County.

What this "depletion" means is that there will be no funds to pay for medical services of referrals or emergency services outside of what the Albuquerque Service Unit can provide in its hospital and field clinics.

The medical staff and I are working on a plan to pre-pay for OB deliveries that are scheduled to occur in August and September. The medical staff's opinion is that it will be a better option to support the continuity of care that has already been initiated for the OB patients.

This depletion of contract health services funds means that the referrals will still be made, however, the payment for medical services will not be possible due to "lack of resources". The referral is to be clearly marked that it will not be paid by the Albuquerque Service Unit.

An additional $550,000 will be given to ASU that will increase the base allocation from $2,922,006 to $3,245,906. There is every indication that no additional funds will be allocated from the Area office and thus far, there is a "no additional funds" response from IHS Headquarters for coverage of the CHS eligible urban Indians.

The impact of the CHS eligible patient load has been duly reported through channels to IHS Headquarters. The information has also been placed before the ASU Governing Board, ASU Indian Health Board, Santa Fe Indian Health Board and the Ten Southern Pueblo Council.

On October 1, 1989, the new eligibility rule will cause an additional CHS workload to occur for the Albuquerque Service Unit. In addition to the 9000 pueblo and the now eligible 9000 urban Indians, the remaining urban Indian population in Albuquerque becomes eligible for contract health services funds. Currently, there are 34,210 registered Indians at ASU. If the base allocation is $2,922,006 for FY-90, then the depletion of CHS funds will occur as early as March if the new eligibility rule is released.

This letter is to inform you of the shortfall programmed currently and the impact of new CHS eligible patients next budget year.

Sincerely,

Raymond L. Reggard
Service Unit Director
Albuquerque ...

cc: ASU Medical Staff
ASU Department Heads

ATTACHMENT 3

April 13, [illegible]
[illegible]el P. Biernoff, M.D.
[illegible]rdo Gonzales, Ph.D.

DULCE

ADOLESCENT SUICIDE

I. STATEMENT OF THE PROBLEM

A. Adolescent Suicide Attempts

Dulce total population - 1989: 2,429 people

Dulce with a high percentage of young people
60 percent of total population is under 24 years
(IHS Population data - 1985).

In a 12-month period (January 1988 - December 1988) 21 Dulce youth age 15-24 years were hospitalized at Santa Fe Indian Hospital for suicide attempts. (These attempts by youth represent 84 percent of the total Dulce suicide attempts hospitalized at Santa Fe Indian Hospital in this period.) Eight of those 21 (38%) were males. This trend of frequent suicide attempts by adolescents from Dulce has continued.

These 21 suicide attempts by youth age 15-24 years represent an age adjusted suicide attempt rate of approximately $\frac{4,142}{100,000}$ which is almost 15 times the estimated national rate of adolescent suicide attempts.

Calculations: Total Dulce pop. age 15-24 yrs. 1985 = 507

$$\frac{21}{507} = \frac{[4,142]}{100,000}$$

Nationally, adolescent completed suicide rate is about $\frac{22}{100,000}$ and the ratio of attempts to completes is estimated to be 13:1 or $\frac{286}{100,000}$.

Dulce's rate of $\frac{4,142}{100,000}$ is almost 15 times $\frac{286}{100,000}$

For all New Mexico Indians age 15-24 years for the period 1973 - 1979 (using an estimated high ratio of 17 attempts to each complete) one would expect a suicide attempt rate of $\frac{916}{100,000}$.

Dulce's adolescent suicide attempt rate of $\frac{4,142}{100,000}$ is almost five times as high.

Page 2 - [illegible]

The ratio of Dulce adolescent suicide attempts to Dulce completed adolescent suicides is 1-1/2 times that reported for any other Native American population.

Calculation: Dulce suicide attempts occur in a ratio of 26:1 when compared with Dulce completed adolescent suicides. The previously reported high Native American suicide attempt ratio of attempts to completes is 17.5 to 1.

In the three-year period 1980-1982 at Dulce, 46 percent of recorded suicide attempts (12 of 26) were made by youth under 21 years.

84 percent of the recent suicide attempts were made by youth 15-21 years.

The increase in rates over this period for adolescent attempts and the almost doubling of percent of adolescent attempts when compared to all attempts is alarming.

It is estimated that as many as 10 percent of Dulce adolescents have made a suicide attempt in the last 1-1/2 years.

Calculation: 278 Dulce youth age 15-19 years (IHS Population data/1985)

27 adolescent suicide attempts age 15-21 years hospitalized at Santa Fe Indian Hospital.

Although the current Dulce youth population is greater than shown above and some of the attempts are repeats, it is felt that a significant number of gestures/attempts were never hospitalized at Santa Fe Indian Hospital.

B. Adolescent Completed Suicide

In the period 1983-1988 (6 yrs.) 11 suicides were reported for Dulce of which five occurred in the age group 24 years and under.

Dulce suicide rate averaged over 1983-1988 = $\frac{81}{100,000}$.

Age adjusted Dulce adolescent suicide rate age 15-24 years for 1983-1988 = $\frac{158}{100,000}$ which is approximately seven times the current national adolescent average of $\frac{22}{100,000}$.

STATEMENT OF THE PROBLEM

Rates of adolescent suicide among the Jicarilla Apache Indians are extremely high. These rates (both attempts and completions) are symptoms of a gradually eroding Indian community that is plagued by social, cultural, and economic problems. These high rates correspond also to the gradual disintegration of Indian family life in Dulce.

It is estimated that as many as 10% of Dulce adolescents between the ages 15-19 have made a suicide attempt in the last one and a half years (January 1988 through May 1989). Based on Indian Health Service (IHS) population data of 1985 there was a total of 278 adolescents in this age range. A total of 27 adolescent suicide attempts were recorded during this time frame based on hospitalizations at the Santa Fe Indian Hospital (SFIH), a Public Health Service facility approximately 200 miles southeast of Dulce. Although the current Dulce youth population is greater than shown for 1985 and some of the attempts are repeat attempts, it is felt that a significant number of suicide attempts were never hospitalized at the SFIH.

January 1988 through December 1988, 21 Dulce (Jicarilla Apache) youth ages 15-24 were hospitalized at the SFIH for suicide attempts. These attempts by youth represent 84% of the total Dulce (Jicarilla Apache) suicide attempts hospitalized at the SFIH during this period. Eight of the 21 (38%) were males. The trend of frequent suicide attempts by Jicarilla Apache adolescents living in Dulce is startling when compared with national adolescent and other Indian adolescent rates. The Dulce adolescent attempt rate is almost 15 times the national adolescent average (total Dulce population ages 15-25 for 1985 =

P. May, 1979).

times as high when comparing all other New Mexico Indians (916/100....see P. May, 1979).

The ratio of Dulce adolescent suicide attempts to completions is one and a half times that reported for any other Native American population. Specifically, Dulce's adolescent suicide attempts to completed suicides occur at a ratio of 26:1. May (1988) reports several studies with the highest Native American suicide attempt to completion ratio as 17.5:1. These ratios suggest that younger age groups among the Jicarilla Apache in Dulce are significantly more affected by suicide attempts than any other Indian community nationally. These adolescents rates also are on the increase. For example, for a three year period (1980-1982) Dulce recorded 46% (12 of 26) of the youth under the age 21 with suicide attempts. This rate remarkably contrasts with the 84% rate recorded for 1988. The increase in adolescents making suicide attempts over this period has almost doubled.

Eleven suicides were recorded for Dulce between 1983-1988 (6 years). Five of these suicides were under the age of 24. The age adjusted Dulce adolescent suicide rate for ages 15-24 for this period is seven times the current national adolescent average (Dulce adolescent - 158/100,000 versus national average - 22/100,000). Generally rates of suicide in Dulce among the youth are similar to other Indian tribes.

Medical records at the SFIH of 14 Jicarilla Apache adolescent suicide attempts were examined between the months January 1988 through April 1988. The social histories of these individuals reveal that they come from exceedingly dysfunctional family backgrounds whose parents have serious marital conflicts

[illegible] alcoholism. These individuals also have histories where they've been physically or sexually abused by their parents. Repeat attempts come from family environments that are increasingly more unstable and chaotic. For example, brothers and or sisters have trouble with the law, they have problems with drug and alcohol abuse; other family members have suicide attempts, and the parents are usually deviant psychiatricly.

Because of these early and unstable family experiences adolescents develop limited adaptive and healthy ways of coping with life's problems. Stresses normally encountered developmentally during teenage years (e.g., dealing appropriately with sex, peer relationships, drugs, achievement, independence from parents, etc.) usually precipitate a suicide attempt. Psychological efforts to intervene with the individual and in the family (e.g., through hospitalization, individual and family counseling, drug rehabilitation, etc.) help to prevent the reoccurence of suicide with the identified patient, but the problems of youth suicide in general have only worsened in the Dulce community.

Major social system related problems perpetuate the high rates of youth suicide in Dulce. For example, the legal system allows for the jailing of youth. The process of jailing youth, however, only leads to emotional trauma, further alienation, and continued anger at authority figures. Studies have shown (Dizmang, 1974) that Indian youth who live on the reservation and have been jailed have suicide attempts in their histories. In the 14 suicide attempts studied 5 individuals had been jailed for behavior related problems with their parents or while living at the dormitory (e.g., running away, AWOL's from the dorm, drug/alcohol misuse, oppositional behavior that is difficult [illegible] going before the court system don't have legal

[illegible] receive counseling with their youth as dispositions on these cases. Therefore the real causes for these youth coming before the court are never resolved. Additionally, the juvenile code is vaguely written and does not allow for the clear delineation of youth with different types of behavioral problems. Youth going before the court subsequently doesn't receive the type of care they require.

Another major social system related problem occurs within the school system. Of the 14 suicide attempts studied nine individuals had been suspended or had dropped out of school. Suspensions are usually drug related. They are initiated by administrative staff, however, without working cooperatively with other care giving professionals (e.g., counselors, teachers etc.) in these dispositions. One such occurrence by an administrative staff led to the completed suicide of a 16-year-old male in May 1988. This had been the first incident in which the youth had been caught smoking marijuana. Generally speaking the school system does not work in a cooperative fashion with the resource network in the school nor with the resource network outside the school to identify youth at risk (e.g., suicidal, drug problemed youth, pregnant females) and to prevent suspensions and or dropouts. The school might be considered the last link in the healthy adjustment of these youth particularly if they come from unstable family backgrounds. Yet the school's lack of tolerance with problemed adolescent behavior reflects more a lack of patience and failure to nurture healthy development with these youth which partly contributes to their problemed adjustment.

A third major problem involves that a alcoholism within the community. Of the 14 suicide attempts studied 14 were alcohol related. Specifically the identified patient and or family members used or abused alcohol. The severity [illegible]

[illegible] alcohol conditions for medical [illegible] problems (e.g. gastrointestinal bleeding, hepatic encephalopathy, cirrhosis, withdrawal). Most admissions for acute inpatient alcohol related medical care come from Dulce (25%). The next highest community is that of Santo Domingo Pueblo with 13% (Santo Domingo Pueblo is thirty miles south of the SFIH; approximately 12 tribes are serviced by the SFIH). Numerous studies have convincingly shown that where there is violence in families of the type previously discussed, alcoholism is associated. The data on youth suicide here in Dulce bear this out. It is emphasized that alcoholism in this community is destroying the fabric of family life for many individuals medically and socially. The causes of alcoholism within Dulce may be too numerous to delineate here but social factors such as the high unemployment rate, reliance on per capital monies which may foster development of poor work habits and dependency, and a tribally owned and operated liquor store in the community obviously play a part.

Numerous risk factors (e.g., individual, family, social) have been delineated in this paper as they relate to the target disease of adolescent suicide in Dulce. It is most critical to underscore that youth suicide in this community is a social problem. No one risk factor discussed above if targeted alone will help to eradicate the problem of youth suicide. The problem of youth suicide discussed above suggests that for many years there has been a community pattern of dysfunctional coping in Dulce, with a longstanding seemingly lack of awareness and failure to deal appropriately with many social ills.

II. CURRENT LEVEL OF SERVICES

Mental health services at Dulce at the present time consist of one full-time mental health worker (paraprofessional) and approximately two days per week of services by a contract psychologist or family therapist.

The community school utilizes a psychologist for its special education students approximately two days per week.

The State-funded mental health program for Northern New Mexico provides no services for Dulce. The nearest psychiatric hospital is in Santa Fe approximately 2-1/2 hours away by car.

Current mental health services are clearly inadequate given the need.

III. RECOMMENDATIONS

A. Mental Health Services

1. Outpatient/Community Mental Health Program

In addition to the existing Mental Health Technician add three mental health positions:

(1) Psychologist
(2) Psychiatric Social Worker or Psychiatric Nurse
(3) Secretary

(See Page 5 for staffing and costs.)

2. Residential Mental Health Program

Develop 8-10 bed residential mental health program that will provide a structured, therapeutic residential environment in the community for youth with behavioral/emotional disturbance including substance abuse, depression.

This progam will interface with the outpatient/community mental health service and other programs including schools, Social Service, substance abuse program, and courts.

Requires 17-1/2 staff positions to provide national standard of 1.7 staff/client for residential treatment programs.

(See Page 5 for staffing and costs.)

B. 1. Tribal Council should consider establishing committee including council members and representative from relevant programs (e.g., courts, schools, mental health, Social Service, youth program) to address problems of youth plus develop a comprehensive plan of action to remedy problems.

2. Tribal Council should consider developing a position of Behavioral Health Coordinator (M.S.W. OR MA in psychology or counselling) whose role would coordinate services provided by the multiple agencies serving youth.

3. Health Promotion should be emphasized in addressing the problems facing youth. A community-wide health promotion program should be considered part of the action plan developed by the tribal committee.

B. 1. committee should be composed of individuals who are involved in the policy making of this community; they should include leaders whose recommendations direct changes in this community (i.e., social, legal, economic)

(e.g., Tribal Council members, BIA Social Services, JADE, Tribal Court, Tribal Police, BIA Law Enforcement, PHS-IHS, Tribal Health Dept., Tribal Multi-Service Dept., Dulce School District Superintendent and School Board)

2. Behavioral Health Coordinator might oversee the functioning of the committee

3. Health Promotion Areas:
-grant and proposal writing to obtain monies through the Federal Government, Dept. of Justice, and New Mexico State Mental Health Bureau
-explore alternatives when detaining youth rather than use of of a jail; detoxify youth with drug related problems rather than use of jail; rewrite juvenile code to better define problemed youth; employ advocate for the youth (or neutral fact finder) when going to court
-better access to state resources (e.g., Tribal/State working agreements; transfer of jurisdictional powers to State court with juvenile cases where there is severe emotional impairment or cases involving severe delinquent behavior)
-improve networking/communication between school administrative personnel and health care professionals with youth identified at risk and or with drug related problems; develop prevention projects in the school around youth suicide, drug abuse, pregnancy, and dropping out of school
-periodic reviews of health related programs presently in operation to insure that programs function ethically and in ways that meet the needs of the community
-through church and community organizations expose parents to educational topics such as parenting, drug/alcohol abuse, depression, etc
-do away with the community problem involving alcoholism (Several Native Indian communities in British Columbia and Alaska have experienced these problems as a result of the rapid acculturation they have been exposed to...e.g.,Alkali Lake. Several of these communities have survived these problems through a process of working together, organizational redevelopment with an emphasis on health education, economic and cultural development, and spiritual education

[illegible]

[illegible]

I. Outpatient/Community Mental Health Program

Position	Level*	Salary		Benefits		Total
Psychologist	GS-12	34,580	+	5,187	=	39,767
Psychiatric Social Worker/ Psychiatric Nurse	GS-11	28,852	+	4,328	=	33,180
Mental Health Technician**	GS-08					
Secretary	GS-04	14,067	+	2,110	=	16,177
						89,124

Plus Vehicles, Travel, Training, Supplies, etc.

II. Residential Mental Health Program

Position	Level	Number of Positions	Salary	Benefits	Total
Program Director	GS-11/12	1	34,580	+ 5,187	= 39,767
Residential Supervisor	GS-07	1	19,493	+ 2,924	= 22,417
Residential Staff	GS-05 GS-06	7 5	197,876	+ 29,681	= 227,557
Secretary	GS-04	1	14,067	+ 2,110	= 16,177
Chemical Dependence Counselor	GS-09		11,923	+ 1,788	= 13,711
Social Worker/Family Therapist	GS-11		14,426	+ 2,164	= 16,590
Recreation Therapist	GS-09/11		11,923	+ 1,788	= 13,711
Special Ed. Teacher (provided by school)					
					349,930

Plus Vehicles, Travel, Training, Food, Supplies, etc.

Outpatient/Community Mental Health Program	$ 89,124
Residential Mental Health Program	$349,930
Total Estimated Staffing Cost:	$439,054

*Federal Civil Service GS levels provided for comparison purposes
**IHS currently filled

ATTACHMENT 4

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

Date May 12, 1989

From Earlene S. Groseclose, PHN/SCHC

Subject Staffing for the Northern Native American Communities

To Indian Health Board

This is an impact statement on how PHN services will be affected by not filling the PHN position for Tesuque, Nambe, Pojoaque, and San Ildefonso. The PHN for Santa Clara/San Juan will pick up the workload of these areas.

The following PHN services will be decreased or not provided because of the increased workload, especially if this is a long term situation.

-Most DP/HP activities will be decreased or halted such as:
  - Routine PN homevisits
  - Well child homevisits
  - Elderly, uncomplicated HV's
  - Families that have not been seen by the PHN for several years
  - Programs targeted at the youth and children
  - Education programs for the elderly, tribe or schools

-Hospital D/C clients will be seen on the basis of chronicity or high risk.
-Prenatal and postpartums will be seen if they are social or medical high risk.
-Children will be seen if the situation is high risk.
-Tracking of children delinquent in immunizations will be referred to the CHR programs.
-Clients discharged from the hospital with alcoholism, social service or mental health needs will be followed by that perspective department.
-Clients from the pueblos, living outside the pueblos will not receive homevisits.
-PHN had planned to spend time with tribal programs to train and assist tribal workers in activities for self determination.
-The PHN has her own caseload, besides the above that will be decreased.
-School health screening done by the PHN, may be deferred or deleted.

PHN will be on maternity leave in September and plans for coverage are not known.

As a further note, the below are population figures for 1980 (except San Juan Pueblo, which is 1987).

Santa Clara	2699
San Juan	1821
Nambe	234
Tesuque	287
San Ildefonso	491
Pojoaque	112
Total Population	5644

In 1985, according to Silvia Rhoades, there should be one PHN for every 1250 population. This means that for this population there should be 4.5 PHN's.

Another study determining resources allocation used population figures of 2665. Even though these population figures are low, the RRMNA of May 19, 1988 indicates that for this population figure two PHN's are required.

ATTACHMENT 5

SANTA FE SERVICE UNIT
EQUIPMENT
FY 1989

1.	Corometer Fetal Monitor	$ 9,849.75	OB
2.	Wheelchairs (8)	10,051.40	Santa Fe Hospital
3.	Qximater	10,050.00	GMS
4.	Ventilator	23,398.44	ICU
5.	Vital Check	2,260.25	Dulce
6.	Pediatric Scale	2,000.00	OPD
7.	Digital Bedside Scale	2,398.50	GMS
8.	Doppler Fetoscope	800.00	Southern Clinics
9.	Laprascope	7,474.00	OR
10.	Toaster	301.99	Dietary
11.	Refrigerator	670.00	OPD
12.	Dermatone	3,095.00	OR
13.	Tympanometer	1,534.10	Dulce
14.	Washer/Dryer	1,028.00	Housekeeping
15.	Scale Upright	314.00	OPD
16.	Accheck	226.00	Dulce
17.	Otoscope	413.50	Dulce
18.	Tympanometer	7,000.00	Santa Clara
19.	Humphrey's Analyzer	18,000.00	Optometry
20.	Doppler	800.00	OPD
21.	Monitor Vital Sign	2,009.00	OPD
22.	Incubator	435.60	Laboratory
23.	Sump Pump	404.06	Maintenance
24.	Embosser	12,778.00	Medical Records
25.	Addressograph	808.04	Southern Clinics
26.	EKG	5,000.00	Taos
27.	Refrigerator	425.25	Southern Clinics
28.	Drug-O-Matic	3,269.00	Pharmacy
	TOTAL:	$127,814.88	

Attachment 6

THE SANTA FE SERVICE UNIT AND CHRONIC ILLNESS:

A PRELIMINARY REPORT

WALLACE J. MULLIGAN, M.D., F.A.C.P.
DIRECTOR, INTERNAL MEDICINE SERVICE

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The IHS Primary Care Provider, Vol. 14, No. 2, February 1989

THE SANTA FE SERVICE UNIT AND CHRONIC ILLNESS: A PRELIMINARY REPORT

INTRODUCTION

The Santa Fe Public Health Service Hospital is an acute care facility with an inpatient service of about thirty five beds. Specialty services include an obstetrics and an active general medical service that cares for surgical, medical, pediatric, and gynecologic patients; an intensive care unit of four beds is used for severely ill patients.

Outpatient facilities include a full time clinic with four physicians on the Jicarilla Reservation with twenty-four hour coverage; a full time clinic with a physician in attendance daily at Taos Pueblo; the Santa Clara Clinic, the three southern clinics at Cochiti, San Felipe and Santo Domingo are staffed by a full time physician, pharmacy practitioner and a physician's associate. Outpatient services at the PHS Hospital include walk-in services, outpatient clinics in the aforementioned specialties plus dental, optometry, physical medicine, mental health and conslulting clinics in urology, orthopedics, dermatology, and ear, nose, and throat.

Community health nurses provide aftercare and home visits; mental health and social services, including an alcoholism counsellor complement provider services. Finally, adolescent health services are provided at St. Catherine Indian School (and complemented by PHS provider services) and the Santa Fe Indian School Health Care Program is contracted by the Santa Fe PHS.

Health providers from the pueblos including Community Health Representatives (CHR's) alcoholism workers, and medical technicians who complement the continuum of services. In addition, outreach services in dentistry, optomety, social sevices and mental health are in place in the pueblos.

All providers have noticed that an increasing amount of time, services, and finances are spent in treating patients with excerbations of chronic illness; although the spectrum is broad enough to include diabetes, paraplegia, social problems and chronic illness in children, two population subsets account for a significant number of inpatient hospital days: alcoholism and the problems of the elderly.

The elderly population is susceptible to many illnesses and injuries and although over ninety percent of those over sixty five years of age are either healthy and independent or cared for by loving families a significant number of patients require extended care on a continuous basis. Physicians from the PHS care for patients without the Service Unit being compensated at nursing homes in Santa Fe, Espanola, and occasionally in Bloomfield. Although the extended care facility is often misperceived as abandonment, realistic appraisals of home situations and patient illnesses often reveal that care requires skilled nurses, attendant physicians and multiple support services.

Alcoholism presents an entirely different problem. This poorly understood behavior disorder and/or illness with an ill defined genetic effect has had extensive review by two retrospective inpatient reviews at the Santa Fe Indian Hospital in 1982 and 1986. The alarming increase in admissions and patients is self evident. The difficulty arises when patients are discharged from an acute care facility; extensive outpatient aftercare services are essential. Yeoman work is being done with limited funds, personnel, and physical facilities at places such as RAP, the Santa Clara Alcoholism Center, Hoy and Embudo. However it is apparent that an inpatient rehabilitation service at the Santa Fe PHS is a facility quite urgently needed to best serve our patients. Like the extended care facility for the aged, the proposal necessitates a physical plant with trained and experienced personnel.

Essentially, both responsible members from the communities and caregivers realize the need for a chronic care facility at the Santa Fe PHS Hospital. This would, of course, mean a revision of IHS philosophy, a larger physical plant, an expanded staff and additional personnel. Disease prevention and health promotion, in addition to an improved quality of life for our patients, would be well served by such a facility.

I. THE ELDERLY

The elderly patients present special problems for acute care hospitals. Because of compromised hearing, seeing, coupled with gait disorders and multiple medicines and illnesses, they are especially likely to become confused, frightened and disoriented in a hospital setting. Federal guidelines for hospital safety (fire lanes etc.) often preclude common sense approaches to nursing care i.e., bringing the patient's bed to the nursing station for observation. Because the elderly patient, more than others, requires extensive assistance in activities of daily living (ADL) such as eating, walking and hygiene, much of the skilled nursing care is devoted to caregiver functions and as a result other patients needing skilled nursing care are deprived of necessary care.

Elderly patients are more likely to have multiple illnesses, problems with urine and bowels and suffer disabling and permanent catastrophies compromising mobility, self care, independence and self esteem. In addition, the elderly suffer from loss of friends and are acutely aware of death as an inevitable consequence of many illnesses.

Many times, caregivers at home suffer from guilt, fatigue, interrupted interpersonal relationships and burn out. Because untoward events such as falls, strokes, and fractured hips occur without a precipitating event, caregivers often incorrectly assume responsibility for the event and not infrequently are blamed by community and family as inadequate for the care. Because care in a skilled extended care facility is directed toward obviating mishaps, such incidents hopefully can be minimized.

Care of the elderly requires multiple disciplines and support systems including nursing, optomety, audiology, social services, pharmacy, physical medicine, mental health and physicians trained in the care of the aged. All these systems are already in place at the Santa Fe PHS Hospital. An extended care unit for the elderly would offer badly needed services for the geriatric population.

Community representatives and community health nurses acknowledge the need for such a facility and although precise numbers are lacking, each community knows of up to fifteen or twenty persons who, reluctant to go to an outside facility would accept a care facility run by Native Americans, especially at "our hospital" in Santa Fe. The governors of the eight northern pueblos were approached by representatives of the Santa Fe PHS in August of 1988 and endorsed the concept and contacted Senator Bingaman who asked Dr. Rhodes, the Director of the Indian Health Service, if discretionary funds were available for an extended care facility; the reply was negative. Informal discussions with governors and other community leaders from the pueblos indicate a favorable attitude toward such a facility.

In conclusion, there has been a change in the spectrum of patients seen at the Santa Fe Indian Hospital. Elderly people from our service unit, with multiple illnesses and impoverished social circumstances, deserve their own facility here at the Santa Fe Public Health Service Hospital.

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II. THE ALCOHOLICS

The alcoholics present a unique subset of patients. The definition or classification as a "disease" is not well founded in scientific data; the genetic part of the disorder is acknowledged but poorly understood. The alcoholism itself is not a disorder treated but physicians in a hospital setting; in the hospital itself, however the effects of alcohol and other chemicals become evident.

Alcohol, as a prototype, is a chemical with profound direct toxic effects on many organs of the body and is a predisposing factor is many other illnesses such as aspiration pneumonia, withdrawal seizures and subdural hematomas.

People under the influence of alcohol are destructive social beings and alcohol is well known as an associated factor in domestic violence, wife and child abuse, motor vehicle accidents and many violent crimes.

The most essential element in care of alcoholics and their codependents is an intense in house rehabilitation program with a structured aftercare program. Because alcohol affects people of all ages and has different effects on adolescents, women and the elderly, special programs, for each group are necessary.

The need for an alcoholic rehabilitation center is obvious to community leaders, CHRs, families and physicians. The data show a trend of alarming increases in women, young people and patients of all ages requiring admission to the Santa Fe Indian Hospital.

The "alcohol program" consists of a single overworked counsellor. Although our current rehabilitation programs do outstanding work, it's obvious the programs are strapped by limited training for the personnel, small physical plants and inadequate outpatient follow up programs.

Structured formal inpatient rehabilitation programs with aftercare follow up involving family, employers, and community are essential. Attention to special groups such as codependents, adolescents, and pregnant women. This cannot be effectively brought about without a physical building, trained personnel and formal rehabilitation programs.

APPENDIX I

PATIENT STATISTICS

JANUARY 1 TO DECEMBER 31, 1988

Patients 65 Years of Age & Older		All Other Patients	
Patients Discharged	233	Patients Discharged	2,381
		Minus OB & Newborn	1,482
Days of Service	1,923	Days of Service	10,095
		Minus OB & Newborn (1,888)	8,207
Average Length of Stay	8.3	Average Length of Stay	4.2

15.72% of patients admitted to the Santa Fe Indian Hospital are over 65.

23.43% of service days are provided to patient over 65.

Average length of stay for patients 65 and over is 50.60% longer than for all other patients

APPENDIX II

THE 1986 ADMISSIONS

A) DEMOGRAPHIC DATA

1) Not Applicable

2) Not Applicable

3) Date of Birth (Age)

	Patients	Admissions
Less than 20	3	3
20-29	26	43
30-39	40	70
40-49	33	51
50-59	19	32
60-69	11	12
70-79	3	3
Greater than 80	2	3

4) Gender

Males	Females
113 patients	24 patients
185 admissions	32 admissions

5) Residence Statistics

Residence	Patients	Admissions
Dulce	30	40
Santo Domingo	25	39
Taos	12	22
Santa Fe	10	21
San Juan	8	14
San Felipe	7	10
Espanola	6	12
Santa Clara	6	11
Cochiti	3	7
Albuquerque	2	2
Picuris	2	3
San Ildefonso	2	2
Nambe	1	1
Other	23	34

6) Tribal Affiliation

Tribe	Patients	Admissions
Apache (006)	28	39
Santo Domingo (120)	24	39
Taos (121)	12	22
San Juan (006)	9	14
Navajo (119)	8	15
Santa Clara (119)	7	14
San Felipe (115)	7	10
Cochiti (108)	4	7
Picuris (113)	4	5
Nambe (112)	3	5
Laguna (111)	3	3
Tesuque (122)	3	9
Cheyenne (026)	3	4
San Ildefonso (116)	2	2
Ponca (102)	2	2
Jemez (110)	2	2
Apache (004)	2	3
Sioux (045)	2	5
Blackfeet (015)	1	4
Comanche (039)	1	1
Arapahoe-Apache (012)	1	1
Pojoaque (100)	1	2
Tovaoc (166)	1	1
Yakima (174)	1	2
Assiniboine (013)	1	1
Choctaw (031)	1	1
Kiowa (062)	1	1
Satsop (066)	1	1
Papago (096)	1	1
Mescalero (008)	1	1
Hopi (54)	0	0
Zuni (124)	0	0
Ponca (098)	0	0
Osage (091)	0	0

7) Marital Status

Single	58
Married	32
Divorced	20
Widowed	15
Not Stated	12
Total	137

8) Family History of Alcohol Use

Not Stated	128
Yes	8
No	1
Total	137

9) Employment Status

Not Employed	84
Employed	49
Not Stated	4
Total	137

10) Other Substance Abuse

No	4
Not Available	203
Yes	10
Total	217

Comment:

The demographic data reveal a curious profile: the prototype patient is male, between twenty and fifty, unemployed, single, who stays in the hospital less than six days and is probably from Dulce or Santo Domingo.

There has been a dramatic increase in patients from a variety of tribes that have been admitted to the hospital and this probably represents the cross cultural population that visits Santa Fe; in addition the Institute of American Indian Arts, in Santa Fe, draws students from all over the country. The Navajo patients account for about 7% of the admissions; more than Tesuque, Cochiti, Santa Clara, Picuris, Pojoaque or San Felipe.

There is a noticeable lack of use of other drugs; only ten of the admissions (about four percent) reflected associated recreational drug use but this figure may be falsely low because it may have been denied or not actively sought.

APPENDIX III

A COMPARISON OF 1982 AND 1986 ALCOHOL-RELATED ADMISSIONS TO THE INPATIENT SERVICE OF THE SANTA FE INDIAN HOSPITAL

A) DEMOGRAPHIC DATA

1) Age by Decades

	1982	1986	
	Patients	Patients	Admissions
Less Than 20	0	3	3
20 - 29	8	26	43
30 - 39	14	40	70
40 - 49	13	33	51
50 - 59	6	19	32
60 - 69	8	11	12
70 - 79	2	3	3
Greater Than 80	0	2	3
	51	137	217

2) Sex of Patients

1982

Males - 72 admissions
51 patients

Females - 12 admissions
9 patients

1986

Males - 185 admissions
113 patients

Females - 32 admissions
24 patients

3) Residence Statistics

	1982		1986	
Residence	Pts	Adms	Pts	Adms
Dulce	14	21	30	40
San Juan	9	16	8	14
Taos	7	8	12	22
San Felipe	6	10	7	10
Santo Domingo	4	5	25	39
San Ildefonso	3	3	2	2
Nambe	2	4	1	1
Santa Clara	2	3	6	11
Santa Fe	2	3	10	21
Espanola	2	2	6	12
Albuquerque	1	1	2	2
Picuris	1	1	2	3
Cochiti	1	1	3	7
Other	6	6	23	34
	60	84	137	217

4) Tribal Affiliation

Tribe	1982 Pts	1982 Adms	1986 Pts	1986 Adms
Apache (006)	11	16	28	39
San Juan (117)	10	17	9	14
Taos (121)	7	8	12	22
Navajo (084)	4	6	8	15
Santo Domingo 19)	4	5	24	39
Nambe (112)	3	6	3	5
San Felipe (115)	3	3	7	10
Santa Clara (119)	2	3	7	17
Hopi (054)	2	2	0	0
Laguna (111)	2	3	3	3
San Ildefonso (116)	1	1	2	2
Ponca (102)	1	3	2	2
Blackfeet (015)	1	2	1	4
Zuni (124)	1	1	0	0
Tesuque (122)	1	1	3	9
Cochiti (108)	1	1	4	7
Jemez (110)	1	1	2	2
Ponca (098)	1	1	0	0
Commanche (039)	1	1	1	1
Osage (091)	1	1	0	0
Cheyenne (026)	1	1	3	4
Picuris (113)	1	1	4	5
Arapahoe-Apache (012)	0	0	1	1
Pojoaque (100)	0	0	1	2
Towaoc (166)	0	0	1	1
Yakima (174)	0	0	1	2
Apache (004)	0	0	2	3
Assiniboine (013)	0	0	1	1
Choctaw (031)	0	0	1	1
Sioux (045)	0	0	2	5
Kiowa (062)	0	0	1	1
Satsop (066)	0	0	1	1
Papago (096)	0	0	1	1
Mescalero (008)	0	0	1	1
	84	60	217	137

Comment:

The comparison of the admissions and patients (1982 and 1986) reveals a troubling trend. The number of patients has almost tripled, as has the number of women. The number of younger patients (less than thirty years of age) has shown an alarming increase. Several pueblos have remained relatively constant in the number of patients admitted (San Juan, San Felipe) while others have shown dramatic increases (Dulce, Santo Domingo). In addition, many more Native Americans who have come from beyond the Santa Fe Service Unit have used the facility in 1986.

APPENDIX IV

THE IHS PRIMARY CARE PROVIDER

February 1989 Volume 14, Number 2

The IHS Alcoholism Prevention Initiatives

Everett R. Rhoades, MD, Director, Indian Health Service and Thomas R. Burns, Ph.D., Special Assistant to the Chief, Alcoholism and Substance Abuse Program Branch, Rockville, MD.

Abstract

The mortality rate for American Indians/Alaska Natives (AI/AN) fell from 54.4/100,000 in 1978 to 26.1/100,000 in 1985, a decrease of 52 percent. The comparable figures for U.S. All Races were 8.1/100,000 in 1978 and 6.2/100,000 in 1985, a decrease of 23 percent. During this time period the Indian Health Service (IHS) embarked upon a major effort to assimilate and to expand alcoholism programs then transferred from the National Institute of Alcohol Abuse and Alcoholism. Following the completion of the transfer in 1983, the number of programs has nearly doubled (158/309).

This paper provides background information incidental to the development of the IHS alcoholism/substance abuse program efforts. A description of the current program's strengths and needs is detailed and is followed by a review of the Secretarial IHS Alcoholism/Substance Abuse Prevention Initiatives. The goal of achieving an age adjusted AI/AN alcoholism death rate at parity with the U.S. All Races rate by the year 2000 is now established.

Background

The first expression of concern about the destructive effects of alcohol on the lives of Indian people was made over three centuries ago by an Algonquian Chief who supported a Canadian governor's stand against drunkenness. His solution was to hand over drunken tribal members to French authorities for punishment.[1]

A Miami tribal leader in 1802 appealed to President Jefferson for federal intervention in liquor trafficking among Indian people.[1] In the years that followed, many laws were passed to establish the philosophy and practice of prohibition among the Indian people. This practice was abolished in 1953 when tribes gained the **choice** of establishing their reservations as "dry" or "wet."

The IHS assessed the impact of alcoholism on the health care system and the Indian communities from 1968 to 1969. By the time of the publication of the report, "Alcoholism, A High Priority Health Problem" in 1970, Indian leaders were testifying in Congress about the need for additional program response to the alcoholism problem and in support of the passage of the Comprehensive Alcohol Abuse Treatment, Prevention and Rehabilitation Act of 1970 (P.L. 91-616).

A major question emerged in the discussion for P.L. 93-282, Alcoholism and Substance Abuse Programs, (Section 111) about the need for continued support of Indian alcoholism programs. The committee stated:

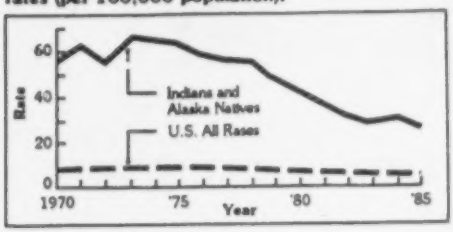
> Under the present policy of the Department of Health, Education and Welfare, National Institute on Alcohol Abuse and Alcoholism, Indian programs are considered to be **for demonstration only** (emphasis added).

The harmful effects of alcoholism were noted and support was given to continue programs beyond the statutorily limited period of six years. (Title II c.(5), P.L. 94-437). In this bill, the Indian Health Care Improvement Act, the IHS was directed to:

1. Remedy the problems experienced with the demonstration phase;
2. Increase public awareness of alcoholism;
3. Change community attitudes;
4. Support rehabilitation;
5. Develop preventive activities for youth, and
6. Design education and training programs in the field of alcoholism.

It is a matter of public record that the IHS goal of elevating the health status of AI/AN extends also to its most important problem, alcoholism.

Figure 1. Progress: age adjusted alcoholism death rates (per 100,000 population).



The Current Situation

Figure 1 graphically shows that since the alcoholism programs were transferred to IHS the age adjusted alcoholism death rates have declined 52 percent. This improvement in health status may be attributed to a number of factors, including availability of alcoholism treatment services, the development of a continuum of care, the emphasis on prevention, provision of education and training to personnel, accident and safety programs, nutrition improvements, and the establishment of inter-agency linkages.

In Table 1 it may be noted that each IHS Area has at least one treatment program. Alaska, Billings, California and Navajo Areas lack halfway houses to provide a full range of treatment services. Seventy percent of the programs are categorized as outpatient/aftercare programs. In large part this distribution reflects the origins of the contract programs.

Table 1. FY 1987 Indian alcoholism and drug abuse programs.

Area	# of Programs	Components: Primary Residential Treatment	Halfway House	Outpatient Aftercare Prevention
Aberdeen	22	4	5	9
Alaska	21	1	0	16
Albuquerque	20	3	3	17
Bemidji	35	1	6	29
Billings	11	2	0	10
California	31	9	0	31
Nashville	19	1	1	10
Navajo	12	5	0	8
Oklahoma	36	8	6	27
Phoenix/Tucson	37	4	1	23
Portland	45	6	1	37
TOTALS	299	42	23	217

(From "A Progress Report on Indian Alcoholism Activities, 1988")

The distribution of new clients into the service delivery system is reflected in Table 2. Of 3,377 clients for whom primary residential treatment was recommended as the treatment of choice, 78 percent were placed at that level. In the same manner, 45 percent of clients were considered appropriately placed in halfway house care.

Table 2. FY 1987 new client treatment needs and placement.

	Primary Residential Treatment	Halfway House	Outpatient
Recommended	3,377	1,060	1,429
Actual	2,621 (78%)	479 (45%)	2,625
Unmet need	756 (22%)	581 (55%)	—

Twenty-four percent of new clients were recommended for placement in outpatient counseling services; yet, 46% of clients were actually placed into this treatment level. It is suggested that this may represent inappropriate placement resulting from the unavailability of the appropriate level of treatment, as for example, the lack of halfway house services in four IHS Areas; alternatively it could be explained by an excess capacity of outpatient care as opposed to other needed resources.

Figure 2. Alcoholism and substance abuse treatment workload.

Outpatient visits at the Indian Health Service alcoholism and substance abuse treatment programs have shown a slight increase since FY 1984, from 336,000 to 364,000. However, inpatient days have decreased since FY 1984, from 205,000 to 186,000.

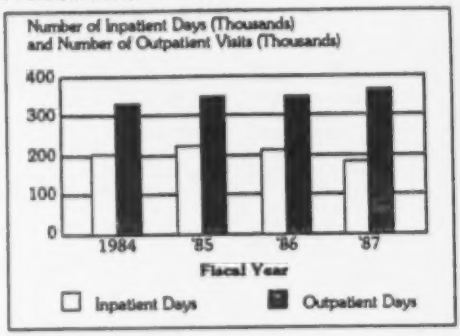


Table 3. IHS alcoholism and substance abuse workload, fiscal years 1984-1987.[1]

	1984	1985	1986	1987
Inpatient Days[2]	205,067	224,078	209,823	186,329
Outpatient Visits[2]	336,161	361,035	358,542	363,960
Unduplicated Count of Clients Treated on an Inpatient and/or Outpatient Basis	20,943	20,793	19,663	19,811

[1] Excludes data for clients treated in the state of Alaska who are reported through the use of state managed reporting system.

[2] This workload does not overlap with workload from IHS and Tribal (direct and contract) inpatient and outpatient facilities.

SOURCE: IHS Alcoholism Treatment and Guidance System (ATGS)

Secretarial Initiatives

On June 3, 1986, the Secretary of the Department of Health and Human Services (DHHS) directed the IHS to

establish a permanent, coordinated effort to reduce alcoholism and substance abuse. The key to this effort was the development of a Task Force and the maintenance of memoranda of agreement with agencies of the Department, in addition to the Department of the Interior and the Bureau of Indian Affairs, as illustrated below.

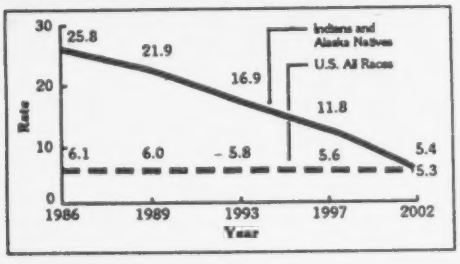
Table 4. The Secretary's Initiative on Indian Alcoholism.

Task Force members — MOAs
- **Alcohol, Drug Abuse, and Mental Health Administration**
  - National Institute of Alcohol Abuse and Alcoholism
  - National Institute of Drug Abuse
  - National Institute of Mental Health
  - Office of Substance Abuse Prevention
- **Office of Human Development Services**
  - Administration for Native Americans
  - Administration for Children, Youth and Families
- **Administration on Aging**
- **Office of Minority Health**
- **Indian Health Service**

Goal for the Year 2002

Given the achievements of the overall alcoholism and substance abuse program effort (IHS, Tribes and contract programs), it is not unreasonable to project that by the year 2002 the age adjusted alcoholism death rates will nearly diminish to the U.S. All Races rate. This has been projected in Figure 3.

Figure 3. Goal Year 2002; age adjusted alcoholism death rates (per 100,000 population).



Objectives

While much has been accomplished, more effort needs to be directed toward the accomplishment of objectives established in FY 1988 in response to the Secretarial Initiatives. For review purposes, these objectives, published elsewhere (IHS Alcoholism and Substance Abuse Prevention Initiative, 1987), are summarized in Table 5.

Table 5. Secretarial objectives for alcoholism and substance abuse, FY 1988-1989.

Objective 1
Fund and evaluate 5 demonstration projects

Objective 2
Youth in need of treatment receive treatment

Objective 3
Eliminate problems of access to treatment in remote areas

Objective 4
Provide aftercare services for discharged youth and adults

Objective 5
Integrate substance abuse services into IHS health delivery system

Objective 6
Certify all counselors

Objective 7
All IHS functions conducted alcohol/drug-free

Objective 8
Provide specialized training to 1,000 IHS/Tribal employees

Summary

The Alcoholism and Substance Abuse Program has been established permanently in the Office of Health Programs. Since the transfer of 158 programs from the National Institute of Alcohol Abuse and Alcoholism the effort has grown substantially, now encompassing 309 programs. Due in part to the Secretarial Initiatives and the Omnibus Drug Bill (P.L. 99-570), greater involvement throughout IHS is apparent from the Department level to the communities. With this spirit and effort our goal of reducing the age-adjusted alcoholism death rates will be achieved near the year 2000. ☐

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ALCOHOLISM TRACKING REPORT
HISTORY OF ALCOHOL INGESTIION
TOTAL NUMBER OF DISCHARGES/UNDUPLICATED
10-01-88 to 03-31-89

Code 134 History of Alcohol Ingestion

COMMUNITY	Discharge	Male	Female	<20	21-30	31-40	41-50	51-60	61-70	71-80	> 81
Cochiti	6	4	2		1		3	1		1	
Jicarilla	23	14	9	2	6	7	4	1	2		1
Nambe	1	1		1							
Picuris	2	1	1			1		1			
Pojoaque	1	1				1					
San Felipe	7	5	2			3	1	1	1		1
San Ildefonso	2	1	1					1	1		
San Juan	13	8	5		4	4		5			
Santa Clara	5	2	3	1				2	2		
Santo. Domingo	11	8	3	1	3	4		1	2		
Taos	6	3	3		3			2	1		
Tesuque	2	2						2			
OTHER											
Oneida	1	1						1			
Ute	1	1			1						
Yakima	1		1		1						
Zuni	1	1				1					
TOTAL	83	53	30	5	19	21	8	18	9	1	2

ALCOHOLISM TRACKING REPORT
CURRENT ALCOHOL INGESTION EPISODE
TOTAL NUMBER OF DISCHARGES/UNDUPLICATED
10-01-88 to 03-31-89

Code 133 Current Alcohol Ingestion Episode

COMMUNITY	Discharge	Male	Female	<20	21-30	31-40	41-50	51-60	61-70	71-80	>81
Cochiti	2	2			1		1				
Jicarilla	26	14	12	2	10	4	5	3	2		
Nambe											
Picuris											
Pojoaque	1	1				1					
San Felipe	2	2				1	1				
San Ildefonso	2		2		1		1				
San Juan	7	7			3	4					
Santa Clara	3	2	1			1		1	1		
Santo Domingo	12	8	4	1	4	6	1				
Taos	7	5	2	1	2	1		2	1		
Tesuque	2	2		1				1			
OTHER											
Chippewa	1	1				1					
Crow of Montana	1	1					1				
N Cheyenne	1	1			1						
Navajo	4	4		2	1					1	
Ute	1	1			1						
Yakima	1		1		1						
TOTAL	75	53	22	7	26	19	10	7	6	1	

ALCOHOLISM TRACKING REPORT
VICTIM ALCOHOL RELATED
TOTAL NUMBER OF DISCHARGES/UNDUPLICATED
10-01-88 to 03-31-89

Code 135 Victim Alcohol Related

COMMUNITY	Discharge	Male	Female	<20	21-30	31-40	41-50	51-60	61-70	71-80	>81
Cochiti											
Jicarilla											
Nambe											
Picuris											
Pojoaque	1	1				1					
San Felipe											
San Ildefonso											
San Juan	1	1				1					
Santa Clara											
Santo Domingo											
Taos	1	1		1							
Tesuque											
OTHER											
TOTAL	3	3	0	1	0	2	0	0	0	0	0

ALCOHOLISM TRACKING REPORT
DOMESTIC VIOLENCE
TOTAL NUMBER OF DISCHARGES/UNDUPLICATED
10-01-88 to 03-31-89

Code 136 Domestic Violence

COMMUNITY	Discharge	Male	Female	< 20	21-30	31-40	41-50	51-60	61-70	71-80	>81
Cochiti											
Jicarilla	3		3			2	1				
Nambe											
Picuris											
Pojoaque	2		2	2							
San Felipe											
San Ildefonso											
San Juan	1		1		1						
Santa Clara	1		1			1					
Santo Domingo											
Taos											
Tesuque											
OTHER											
TOTAL	7	0	7	2	1	3	1	0	0	0	0

ALCOHOLISM TRACKING REPORT
SCREENING CODE TOTALS
10-01-88 TO 03-31-89

	Discharge	Male	Female	<20	21-30	31-40	41-50	51-60	61-70	71-80	>81
Code 133 Current Alcohol Ingestion Episode:	75	53	22	7	26	19	10	7	6	1	0
Code 134 History of Alcohol Ingestion:	83	53	30	5	19	21	8	18	9	1	2
Code 135 Victim Alcohol Related:	3	3	0	1	0	2	0	0	0	0	0
Code 136 Domestic Violence:	7	0	7	2	1	3	1	0	0	0	0
GRAND TOTAL	168	109	59	15	46	45	19	25	15	2	2

EXTENDED CARE AND REHABILITATION NEEDS AT THE SANTA FE PUBLIC HEALTH SERVICE HOSPITAL

OPTIONS AND CONSIDERATIONS

WALLACE J. MULLIGAN, MD

INTRODUCTION

Review of inpatient records over the last several years at the Santa Fe Public Service Hospital, reveals a troubling recurrence of admissions to the hospital because of chronic illness. In previous memorandum to the health board at the Santa Fe Service Unit, data were presented showing that the two areas that most urgently needed addressed were alcohol related and caused illnesses and care of the elderly.

The current situation is one that precludes care of the elderly for extended period of time in an acute care hospital; in those instances when the patient is required to be in a nursing facility, it is necessary that they be placed in a nursing home in Albuquerque, Santa Fe, Bloomfield, Farmington or Espanola. This fragmentation of care is thought to be less than optimal and many families feel as though their chronically ill elderly parents are "being put into a home". Long term care at the Santa Fe Service Unit has been received much more favorably by patients who had been surveyed and would help to mitigate the guilt of the families when the elderly patients need extended care.

Data showed an increasing problem over the years with alcohol caused and related illnesses being admitted to the acute care hospital. This has perceived as limited rehabilitation programs available in the service unit; the need for a long term professionally staff chemical dependence center is obvious. What is not readily apparent is whether or not this needs to be addresed by the Indian Health Service. Certainly, other federal and state agencies could establish a long term rehabilitation center for chemical dependence and alcohol related illnesses without the Indian Health Service being directly involved except in a consulting role; nonetheless, as the need goes unmet and the significant number of people return with alcohol related problems, it becomes apparent that someone should step forth to fill the gap with an extended alcohol rehabilitation program.

I. THE CHEMICAL DEPENDENCE REHABILITATION CENTER

A. BEDS

Any number of beds in a rehabilitation center can be fairly optional depending upon the needs served. This facility would certainly not be a detox facility but would require approximately 20 male and 10 female beds for the clients in a strictly segregated facility. Only meals will be taken together in a group and still the men and women would be separted from each other. Because there is in the Albuquerque Area an adolescent center, that particular group of patients with chemical dependency and alcoholism program would not be taken care of at the center at the Santa Fe Hospital. By the same token outreach programs such as Alateen, Alcoholics Anoymous, and family counselling would not fall within the jurisdication of this inpatient rehabilitation service.

B. PERSONNEL

Naturally, a rehabilitation center requires well trained people and specifically those with education in caring for chemical dependence, chronic illness, and alcohol dependent needs:

1. Administrator
2. Medical Consultant
3. Specially trained nurses
4. Alcoholism counsellor
5. Increase in the dietary personnel
6. Increase in Social Service
7. A separate discharge planner
8. Increase in the Security forces

C. PHYSICAL PLANT

1. The male facility would be structured with 20 beds around a living room type area with kitchen for coffee and snacks
2. The female area would be separate but contructed in a similar way.
3. There will be separate dining areas and the cafeteria that would be separate from the Public Health Service cafeteria and dining area.
4. A small auditorium would be necessary for extended conferences
5. A nondenomination chapel would not be inappropriate.
6. The questions of crafts and occupational therapy is a moot point
7. The existence of a weight room or exerise room for aerobics and physical activities in addition to a jaccuzi is also a moot point.
8. Parking facilities would have to be separate from the acute care parking lot.

D. POLICIES

1. Rehabilitation and not detoxification would be the emphasis.
2. Finances would have to be investigated as funding would be an ongoing problem
3. Rules and regulations would be have to be established for both personnel and clients
4. Arrangements for discharge and aftercare would also be necessary

E. OVERVIEW

An overview of the necessity for an alcohol rehabilitation center would probably require a feasibility study and coordination with other government facilities in order to see if this is truly the responsibility of the Indian Health Service.

II. EXTENDED CARE FACILITY

A. The number of beds would probably be about 35 to care for chronic illness in the Service Unit.

B. Personnel
1. An administrator would be responsible to the Service Unit Director for running of the extended care facility.
2. A full time medical director would be responsible for direct patient care and would have to be separate from the acute care hospital staff and free of weekend and night call.
3. Nurses and aides would be specifically trained in the care of the chronically ill.
4. Physical therapy would be an integral part of the care of the chronically ill.
5. Dietary would need to be a separate unit that would have to meet very many specialized diets.
6. Occupational therapy consult would be essential.
7. Social Services would need to be an independent department within the extended care facility or could be part of an extended resource of the acute care hospital.
8. Mental Health could probably be used as consultants from the acute care hospital.
9. The Public Health Service acute care hospital could supply x-ray and laboratory.

C. THE PHYSICAL PLANT

1. The beds would need to be private and semi-private rooms
2. Separate dining room would be in order
3. A separate parking area would be appropriate
4. A chapel
5. A nurses station would be all necessary parts of the physical plants in addition, hand rails, handicap ramps, and arrangements for special visiting areas would not be inappropriate.

D. POLICIES

1. Federal regulations including Medicare, Indian Health Service and related federal rules would be guidelines that would help in establishing a safe facility.
2. State regulations would also have to be followed.
3. In-house rules and regulations for such things as visitations and policies for care including chart review physician visits, etc, would need to be in place.

III. ALTERNATIVE PLANS

A. Chemical dependency

The question that recurrs is whether or not the inpatient treatment of chemical dependency and alcohol related rehabilitation programs falls within the directive of the Indian Health Service in Santa Fe. Specifically, if this large unmet health need is addressed by the Indian Health Service, would funding be directly from congress or would it be ear marked in conjunction with other federal agencies that may see this as their responsibility. In addition, the question arises to whether or not improving and beefing up current existing alcohol rehabilitation programs would be more cost saving and time saving and be more appropriate than construction of a new facility at the Santa Fe Service Unit Hospital.

B. The question of an intermediate extended care facility established in the present hospital becomes relevant.

1. Social Service, maintenance room, oncall room, and adajacent rooms could be converted into an intermediate care unit of about 15 beds.

   a. This unit could be staffed by a fulltime physician separate from the Indian Health Service, acute care staff without call responsibility. In addition, the nurses should be trained in geriatrics, chronic care and care of the paraplegic.

Social Services, Medical Records, Rehabilitation Service would need additional personnel. In addition, personnel would have to be assessed in dietary, mental health and the dental department.'

Conclusion

There is no question that there are large number of chronic illnesses that are going unmet and at the Santa Fe Service Unit, the recurrence of acute care problems in a population that has a large number of recurrent chronic illnesses necessitates the professionals and the health board to rethink alternatives to caring for these patients and addressing their needs, specifically in the areas of chemical dependence and an extended care unit primarily for the elderly.

Continuing review by the professionals, the health board, and the administrator within the Indian Health Service is necessary, and hopefully, is forthcoming.

ATTACHMENT 7

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

Date March 1, 1989

From Director, Albuquerque Area
Indian Health Service

Subject EPMS Performance Awards Program

To Deputy Director/Executive Officer
Deputy Director/Chief Medical Officer
Service Unit Directors

RECEIVED
1989
PHS INDIAN HOSPITAL
SANTA FE, NEW MEXICO
ADMINISTRATION

By his memorandum of December 9, 1988, Dr. Rhoades announced that IHS will implement the EPMS Performance Awards Program under HHS Instruction 430-5 for the 1988 performance rating period which ended December 31, 1988. In order to proceed with the program, I have established Performance Awards Groups (PAG) and appointed the Award Budget Managers as follows:

PERFORMANCE AWARDS GROUP:	AWARDS BUDGET MANAGER:
Area Office	Deputy Director/Executive Officer and Deputy Director/Chief Medical Officer
Each Service Unit including Health Centers	Service Unit Director

Each Awards Budget Manager will be responsible for (a) approving all ratings for EPMS employees who receive performance awards within the PAG, (b) approving the actual dollar amount of each performance award, (c) determining which Outstanding employees will receive a QSI instead of a performance award based on recommendations from the rating and reviewing officials, and (d) reducing the performance award budget by the amount of money spent on QSI's. In addition, the Awards Budget Manager is the Stage 1 Official in performance appraisal grievances for employees rated excellent or outstanding.

The Employee Relations Officer will perform the technical review of the EPMS ratings and provide guidance to the Awards Budget Managers.

Attached is a copy of Dr. Rhoades' December 9, 1988, memorandum and a copy of the IHS issuance on the EPMS Awards Program. As soon as the budget is received from Headquarters, you will be notified and provided specific guidance on how to calculate the payout. It is of the utmost importance that the 1988 EPMS ratings be forwarded immediately to the Employee Relations Office. If any of your subordinate supervisors failed to put EPMS plans in place for the 1988 rating cycle, you must submit a memorandum identifying the employees who were not provided an EPMS plan and the circumstances surrounding the non-compliance.

I am very interested in the outcome of this program, therefore, your cooperation is expected and appreciated. You may contact Mrs. Tomhave if you have any questions.

DEPARTMENT OF HEALTH & HUMAN SERVICES

RECEIVED
DEC 15 1988
Ofc. of the Director, AAIHS

Memorandum

Date DEC 9 1988

From Director

Subject Employee Performance Management System (EPMS) Performance Award Program

To Area Directors

DEC 15 '88
PERSONNEL

Initials | Date
SCW 12/13/88
OD
EX OFF
THP
Copy to Mr Dillon
For action.

The Public Health Service has announced that all PHS agencies will implement EPMS performance awards under HHS Instruction 430-5 for the 1988 performance rating period which ends December 31, 1988. The Indian Health Service (IHS) has established the following policies and procedures to implement the performance award program:

(1) This program covers all EPMS employees in grades GS-1 to GS-15 and all Wage employees including Wage Grade, Wage Leader, and Wage Supervisor. (The program does not cover SES, PMRS, Commissioned Corps or employees under special recruitment authorities such as Consultants, Experts, Committee Members, etc.).

(2) In order to be eligible to receive a performance award, an employee must (a) have served under a Department EPMS performance plan for 120 days during the calendar year for which the rating is being given, (b) be an EPMS employee on the last day of the appraisal year which is December 31, and (c) receive a rating of either Outstanding or Excellent. The minimum appraisal period shall never be less than 120 days unless a rating is being transferred from an organization outside HHS that has a minimum period of a different length under a plan that was approved by USOPM. An employee who has not received a rating of record is not eligible for a performance award, nor is an employee who is rated Fully Successful. Within-grade increases (WIGI's) are not affected by this program.

(3) An employee cannot receive a Quality Step Increase (QSI) and a performance award based on the same rating of record. Managers recommending a QSI in lieu of a performance award must be certain the following conditions are met: (a) The employee must have an Outstanding rating; (b) The employee cannot be in Step 10 of his/her current grade; (c) The employee cannot be the recipient of a QSI based on his or her rating of record the previous appraisal year; (d) The employee cannot have been promoted during the current appraisal year; and (e) The employee cannot be on a temporary promotion.

(7) Performance awards will be calculated on the employee's base pay as of the last day of the appraisal year (December 31) for which awards are being paid. In the case of part-time employees, calculations should be based on salary actually paid during the appraisal year. Overtime, or any other additional form of compensation will not be used as part of the award calculation. Funding for performance awards will come from a constructed EPMS performance awards budget composed of: 1.5% of the estimated aggregate of EPMS employees' basic pay as of December 31 each year; and 1.5% of EPMS employees' general increases, within-grade increases and quality step increases estimated to be paid during the year. The Public Health Service will provide a performance award budget for each Area, Office of Program Development, and IHS Headquarters.

(8) Each SPO is responsible for processing the appropriate performance award which will be documented on a SF-50 in the Official Personnel Folder and must reflect the nature of the award as well as the amount.

The above policies are effective immediately. Please file this memorandum in Chapter 430 of the Federal Personnel Manual. A manual issuance will be developed in the near future.

for Everett R. Rhoades, M.D.
Assistant Surgeon General

THE EMPLOYEE PERFORMANCE MANAGEMENT SYSTEM (EPMS)
PERFORMANCE AWARD PROGRAM

WHAT IS THE EPMS PERFORMANCE AWARDS PROGRAM?

It is a new program to pay cash ($$$$) bonuses to EPMS employees who are rated Outstanding or Excellent.

Indian Health Service employees who are rated Fully Successful are not eligible for a performance award.

ELIGIBILITY FOR EPMS PERFORMANCE AWARD

IN ORDER TO BE ELIGIBLE TO RECEIVE AN EPMS PERFORMANCE AWARD YOU MUST:

- Serve under an EPMS performance plan for 120 days during the ~~current calender year~~ rating period
- Be an EPMS employee on December 31 of the rating year
- Receive a summary rating of Outstanding or Excellent from the Award Budget Manager
- Not have received a QSI based on the same rating of record

PERFORMANCE AWARD GROUPS

EPMS EMPLOYEES WILL BE GROUPED INTO PERFORMANCE AWARD GROUPS, AS FOLLOWS:

- IHS Headquarters including Albuquerque West.
- Office of Health Program Research and Development (Tucson)
- Each Area

IMPORTANT CONSIDERATIONS GOVERNING PERFORMANCE AWARDS

- An employee with an Outstanding Rating should receive a performance award of at least 2 percent of base pay. (HHS 430-5-70 F2.)
- An employee with an Excellent Rating should receive a performance award. (HHS 430-5-70 F3.)
- The minimum performance award is $100. (HHS 430-5-70 F5.)
- A performance award does not increase your base pay.
- Normally the ratio of Outstanding to Excellent awards in IHS will be 2:1. This means that if Outstandings receive a 2% bonus, then Excellents should receive a 1% bonus.
- Within a Performance Award Group, all Outstanding ratings will receive the same percentage bonus; the same is also true with all Excellent ratings within a group.
- An employee with an Outstanding rating may receive a Quality Step Increase (QSI).
- An employee may NOT receive both a performance award and a QSI in the same year.

HOW IS THE PERFORMANCE AWARD CALCULATED?

- Your salary (base pay) as of December 31 will be used.
- If you work part-time, your salary will be pro-rated based on the number of hours you work each pay period as of December 31.
- Overtime, or any other additional form of compensation, will not be used as part of your salary.
- Employees rated Outstanding will receive a performance award of 3% of their base pay unless it is necessary to reduce this percentage because of the pool fund or budget limitations.
- Employees rated Excellent will receive a performance award based on a 2:1 ratio of Outstanding to Excellent unless it is necessary to reduce this percentage because of the pool fund or budget limitations. (This means if employees rated Outstanding receive a performance award of 3%, employees rated Excellent receive a performance award of 1.5%)
- If a pool fund or budget limitations require a reduction in the amount of performance awards, the percentage for Outstanding and Excellent ratings will be reduced equally until the pool fund or budget limitation is reached. When the percentage for employees with Outstanding ratings is reduced to the minimum of 2% suggested by the Department, further reductions will continue only for employees with Excellent ratings.
- The Award Budget Manager has the authority to determine the final percentages to be used to compute the performance awards within the pool fund established.
- Approval of the Director, IHS is required to reduce the established pool fund because of budget limitations.

GRIEVANCE RIGHTS

- If you believe that your performance appraisal was not correct in one or more element evaluations, you may file a grievance.
- You cannot grieve whether or not you receive a bonus or a QSI.
- You would file your Stage 1 grievance with your Award Budget Manager.

PEREZ EXHIBITS
(morning session)

SPECIAL COMMITTEE ON INVESTIGATIONS
HEARINGS ON INDIAN HEALTH SERVICE
MONDAY, MAY 15, 1989

List of Medical Procedures which cannot be provided at Ft. Belknap (MT) IHS Service Unit Due to Lack of Contract Health Care Funds [list provided by top level personnel at the Ft. Belknap Service Unit]

PROCEDURES & CARE THAT CAN'T BE GIVEN
WHEN CONTRACT HEALTH SERVICE IS AT 13 LEVEL

1. Sexual Abuse Evaluations - Risk of Continuing Abuse, Misdiagnosis
2. Urgent Psychiatric Evaluations in Children or Adults - Risk of Suicide or danger to others; long term behavioral problems in children; substance abuse.
3. Barium Enemas for Heme + Stool - Colonoscopy - Upper GI's Missed Cancers
4. Mammography - Missed Cancers
5. Colposcopy for Abnormal Paps - Missed Cancers
6. Urologic (Cystoscopy) - Evaluation of Hematuria - Chronic Pyelonephritis - Missed Cancers
7. Chronic ENT Pain - Missed Cancers
8. Orthopedic Evaluations for Musculoskelatal Pain causing Dysfunction - Loss of function - Loss of Employment, etc.
9. Neurologic Evaluations for Headaches with Unusual Associated Symptoms or Seizure Disorders - Missed Tumors or Bleeds - Disabling Radiculopathies
10. Obstetrical Care for High Risk Pregnancies ; Abnormalities of Gestation which are not Emergent - High Risk of Poor Outcome of Pregnancy.
11. Cardiology Evaluation of Unstable Angina, Heart Murmurs of Unknown Cause - High Cardiac disability or death.
12. Rheumatologist Evaluations of Difficult-to-Manage Rheumatoid Arthritis, SLE, Scleroderma, other Connective Tissue Diseases - High Dysfunction which may be Irreversible, and Complications.
13. Management of Chronic Renal Failure Requiring Nephrologist and/or Dialysis - Worsening of Renal Failure.
14. Tyroid Scans & Biopsies - Missed Cancers
15. Allergy & Immunology Evaluations - Disabling Allergy Symptoms - Asthma, Hay Fever, Recurring Sinusitis
16. Dermatology Evaluations of Severe or Recalcitrant Rashes - Disabling Rashes - Missed Cancers
17. Pediatric Evaluations of Growth & Developmental Problems such as Strabismus, Attention Deficit Disorders - Permanent Deficits

18. Endometrial Biopsies or D&C's for Diagnosis of Abnormal Uterine Bleeding - Missed Cancers

19. CT Scans for Evaluations of Abnormalities on Chest X-Rays Recommended by Radiologist - Missed Cancers

20. Formal Pulmonary Function Testing - Misdiagnosis of Cardiac or Pulmonary Conditions & Subsequent Mismanagement

21. Surgical Biopsies of Possibly Malignant Lesions or Condyloma - Missed Cancers; Spreading of Condyloma to other People

22. Oral Surgery, Behavioral Management Required for Dental Care in Certain Individuals - Worsening Dental Conditions Including Root Abcesses, Loss of Teeth.

23. Diabetes; Opthalmic Evaluations, Orthopedic, Surgical, Podiatric Evaluations, etc. - Delayed Evaluations result in Complications, i.e. blindness, loss of limb, etc.

LACK OF ADEQUATE FUNDS FOR REFERRAL CARE DIRECTLY CAUSES LOSS OF MORAL AMONG CARE PROVIDERS, PATIENT AND ADMINISTRATIVE STAFF, WHICH IN TURN COULD LEAD TO TURNOVER, LOSS OF RETENTION AND NEGATIVE PUBLIC RELATIONS IN FUTURE RECRUITMENT.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary
for Legislation

Washington, D.C. 20201

AUG 22 1990

The Honorable Dennis DeConcini
Chairman
Special Committee on Investigations
Select Committee on Indian Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Enclosed is a statement by Dr. Everett Rhoades, Director, Indian health Service, prepared for the Committee's hearing record. The statement is intended as a supplement to a statement which Dr. Rhoades had prepared for the Committee's May 15 hearing. For your convenience, we are also enclosing a copy of the May 15 statement.

Sincerely,

Gerald L. Olson
Assistant Secretary
for Legislation

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ADDENDUM

to the

STATEMENT

by

EVERETT R. RHOADES, M.D.
DIRECTOR
INDIAN HEALTH SERVICE

before the

SELECT COMMITTEE ON INDIAN AFFAIRS
SPECIAL COMMITTEE ON INVESTIGATIONS
UNITED STATES SENATE

May 15, 1989

Mr. Chairman and Members of the Committee:

As you are aware, I submitted a statement in anticipation of my scheduled appearance before the Committee on May 15, but I was precluded from participating because of the Committee's concern that the Indian Health Service (IHS) was not fully cooperating with their investigation. This concern was apparently aroused because IHS did not provide requested materials in a timely and organized manner, and because of information that a potential witness may have been pressured to not fully cooperate with the Committee. I assure you that was not our intention and I regret that we may have given you cause for your concerns. Our actions to remedy this will be described at the end of these additional comments.

My earlier statement described program achievements in improving the health status of American Indians and Alaska Natives, in improving the capability and quality of services, and in pioneering community based health promotion and disease prevention activities. I also described management accomplishments and initiatives such as using a fiscal intermediary, implementing a new information system, and making organizational changes since elevation to an agency level within the Public Health Service.

I stated that the various incidents identified by the Committee did not portray a program which was seriously mismanaged. We believe that the situation involving the previous Area Director of the Bemidji Area does not represent the norm in the IHS, because it is the first example of such illegal action by an Area Director in the entire history of the IHS. Other than the situation in the Bemidji Area, I am aware of only one other involving criminal activity in the 34 years of the IHS, an organization comprised of thousands of individuals handling a large amount of resources and executing extraordinary numbers of transactions.

At the May 15 Hearing, a number of very serious and broad allegations were made about the administration and management of IHS's programs. As Director of IHS and ultimately the person responsible for the successes and failures of the agency, it is my duty to respond to those allegations and to present my decisions regarding the management of the IHS. Therefore, I respectfully request that this addendum be made a part of the record of the May 15, 1989 Hearing of the Special Committee on Investigations.

I have organized my response to coincide with what I believe to be the Committee's major concerns as expressed during the May 15 Hearing:

- Waste, abuse, and fraud are pervasive in the Indian Health Service.
- Funds for the problem of alcoholism and alcohol abuse are being inappropriately used, and insufficient funds are directed to this problem .

- o Health status indicators used by IHS to show progress being made in improving health status may be misleading.

- o Resources are not being allocated to areas of greatest need.

I will close with a response to the Committee's strong statements about our lack of cooperation.

Where appropriate, I have referenced attached exhibits that provide additonal information that may be useful to the Committee in understanding the complexities that are often involved in making decisions about IHS programs.

Waste, Abuse, and Fraud

The most damaging of these major concerns was that waste, abuse, and fraud were pervasive in the IHS. This general allegation had not been previously brought to the attention of the IHS. The specific incidents reported in the Hearing were known. Each had been identified by various IHS and Departmental systems and were being dealt with by appropriate means, including referral to the Office of the Inspector General (OIG). The number of incidents cited seemed small both in absolute terms and as percentage of the hundreds of thousands of annual transactions by the more than 11,000 IHS employees.

After the Hearing, I wrote to the OIG to reaffirm our commitment to continue an open and productive relationship aimed at identifying and eliminating waste, abuse, and fraud. I asked for an opportunity both to respond to any information they had or have with which I am unfamiliar and to establish any additonal procedures that will assist the OIG in addressing their concerns. This was followed by a meeting with the Deputy IG for Criminal Investigations, Mr. Larry Morey, and his staff; and the Chief of the Audit Divison of OIG, Mr. Daniel Blades and his staff, and finally a meeting with Inspector General, Mr. Richard Kusserow, and his Deputy, Mr. Brian Michell. I believe we have established a sound basis for future cooperation.

Based on discussions with the OIG, the analysis of material prepared for the Committee, our own review of administrative practices, and an analysis of the May 15 Hearing transcript; we have gained a new awareness of administrative weaknesses that could make IHS vulnerable to waste, abuse, and fraud. The IHS was administratively elevated to Agency within the PHS on January 4, 1988, and is still in the process of growing into its new roles and responsibilities. Our fledgling agency was required to operate with minimal increases in resources. We are moving forward making organizational changes and adding staff as scarce office space becomes available; nevertheless, it is apparent that we have not adequately adjusted to the added oversight and administrative requirements of an agency-level organization, and have not been sufficiently responsive in resolving administrative problems.

The attention of IHS managers and staff is focused on program: assuring that Indians and Alaska Natives in need of health care receive appropriate services in an environment of significantly more demand than available resources. Consequently, we may have exercised poor judgement by our long standing practice of allocating any additional resources to clinical services rather than to administration. In contrast to Dr. Nicholson's perception as he testified before the Committe on May 15, it seems we have been overly responsive to the needs of providers and patients at the service unit level.

I am concerned, however, with the charge that IHS is spending too much on administration and has too large a staff at the Rockville headquarters, while at the same time we are accused of providing insufficient oversight and administration of the program. At Exhibit 1 are two charts which show that the estimated IHS administrative cost is 12.9 percent of the program budget and that this compares favorably with other systems. Headquarters accounts for 2.9 percent of the budget. Full time equivalent (FTE) positions in direct operations have not changed since 1982 even though there has been substantial program growth (Part 2, Exhibit 1). The 295 FTE's in Rockville represent only 2.4 percent of all FTE's in the IHS. Of the 70 FTE's added to Rockville in FY 1989 as a result of elevation, 44 FTE's were transferred with funds from the Health Resources and Services Administration.

Events of the past few months have certainly focused our attention on administrative management. I fully recognize the factors and practices that have caused our present problems, and what must be accomplished to raise our managerial performance to a level of excellence for which both the PHS and Department can be proud.

Consequently, I have taken the following actions to search out and correct our management problems:

- A letter to all voucher examiners offering strong support from the Dirctor, IHS, if they experience any bullying or reprisals for properly doing their jobs.

- On May 29 implemented the Division of Contracts and Grants Policy. By agreement with the Deputy Assistant Secretary for Health Operations, OASH; Mr. Tom Shoe, Director, Division of Contracts and Grants, OASH, has been assigned as Acting Director of this Division, while we search for and select a permanent director. This Division formulates policy for IHS contracts and grants, and conducts oversight reviews of Area Office procurement functions.

- On July 6 assigned to the Director of Headquarters Operations, IHS, responsibility for developing, by August 30, a comprehensive plan for correction of management deficiencies; and responsibility for taking immediate actions to correct deficiencies that are know to us.

- On July 10, issued Special General Memorandum 89-2, requiring a preapproval audit by HRSA, Division of Fiscal Services, of all area director travel claims submitted for reimbursement, and post-approval audits of all travel by other area key staff.

- Established cooperative links with the OIG divisions that are working on IHS investigations, audits, or inspections. As of July 10, responsibility for coordination with OIG was moved into the IHS Director's Office.

- On July 21, established a Quality Management Steering Committee made up of high level PHS and OS representatives to advise and guide our decision making as we change the management practices and structure of IHS.

- Contracted with two consulting firms to assess IHS management and to develop and recommend short and long term plans to correct and strengthen IHS management. Their reports are due August 30.

- Established a Quality Management Initiatives team of key IHS personnel under the direction of the Director of Headquarters Operations to facilitate and monitor activities to correct administrative problems and to improve management.

- On August 1, the IHS Deputy Director and representatives from the consulting firms met with IHS area directors to involve them in the process of making immediate changes to improve managerial performance and to plan long term changes.

- A revised schedule of Executive Management Reviews of Area Offices will have been completed by August 16. A new review structure will focus on the following areas: managerial competence, managerial responsibility, and personal ethics of area directors and their immediate staff. A team including the Deputy Director, Associate Director OHP, and Associate Director OAM will conduct the reviews.

- The number of meetings to be held in IHS has been reduced for the remainder of this year and into the next year. Until a new, permanent policy is in place, we have, on an ad-hoc basis, increased the controls for approval of meetings and conferences.

- Draft guidelines on Health Promotion Disease Prevention activities are out for review and comment by IHS administrative and program staff. These will provide additional guidance for setting objectives, implementing the activities, and evaluating the results.

- By August 20, actions will have been initiated to strengthen our Office of Administrative Management. This will include several personnel changes and perhaps changes in delegations of authority.

- o By September 11 we will have initiated additional corrective actions identified by either my Quality Management Initiatives Team or our outside consultants.

An indepth description of some of these actions is attached at Exhibit 2.

In addition, a current study is examining the feasibility of moving portions of the Rockville headquarters to the field. It is focusing on those components that provide guidance and technical assistance to IHS and tribal health service programs.

The characterization that waste, abuse, and fraud are pervasive in IHS is based on the description of incidents and circumstances in the Bemidji, Oklahoma, and Albuquerque Area involving travel, meetings or conferences, and procurement and contracting activities.

The most unfortunate of these is the above mentioned situation in the Bemidji Area, which to the best of my knowledge involved no more than five employees, none of whom are currently employed by the IHS.

This situation, however, appears to be representative of a more general concern about area director and other key IHS manager travel, especially to attend Council of Area and Associate Directors (CAAD) meetings. In retrospect, the selections of some locations for these meetings were inappropriate. Three meetings were mentioned by Mr. Morey in his testimony before the Committee on May 15. He highlighted the one held in June 1988 on Mackinac Island, Michigan. Since this meeting took place in the recent past and was arranged by the former Bemidji Area Director, who was at the time of the Hearing under indictment by a Grand Jury, I ordered a review of the actions and agreements that allowed the meeting to take place. While all of the documents have not been recovered and analyzed, it is apparent that the former Bemidji Area Director wrongly used a tribal contract to cover meeting costs that should have been paid by the meeting participants. Neither I nor the rest of the Council of Associate and Area Directors had knowledge of his actions. I assure you that a Mackinac Island will not occur in the future. The former Bemidji Area Director, on his own counsel, took totally inappropriate actions to procure this meeting site. Upon learning of the true nature of those actions, I was embarrassed and outraged that the CAADs were made a part of his behavior. When the full costs are known we will take whatever steps are appropriate to ensure full corrective action. Furthermore, a new policy is in place to preaudit the travel of all area directors. SGM 89-2 at Exhibit 3.

I have said that these incidents are unfortunate, because I believe it is necessary for this group of IHS key managers to meet periodically to address the myriad of issues characteristic of an organization as complex and diverse as the IHS. In the past, I encouraged the rotation of meeting locations, always in close proximity to tribes, and tribal and IHS programs. This gave IHS managers the opportunity to visit tribes and programs outside their own areas. The purposes were to broaden their perspective and understanding of programs, and to focus their combined capabilities on issues in that location.

Dr. Nicholson's testimony was also critical of quarterly clinical directors meetings held in the Aberdeen Area. He stated that these meetings just ended up in rhetoric and that the money should be used for health services. Again, I believe that meetings at this level are important for improving the management and delivery of health services. This is particularly true as most of our facilities are in very rural and often isolated locations. These meetings provide opportunities for clinicians to share experiences and to compare methods and practices that are of great value to them personally. In addition, these meetings are used to provide continuing education for physicians and other health professionals that is required to maintain licensure.

We are more often critized from within IHS that we do not have enough meetings and continuing education opportunities, because these are the first activities reduced or eliminated to conserve resources when budget restrictions threaten to erode clinical services.

Alcohol Program Funds

The Sunrise Springs retreat conducted by the Albuquerque Area was presented as another example of possible waste and abuse. In addition, the Committee strongly expressed concern that the IHS was inappropriately using funds intended to treat alcoholism and alcohol abuse, and that insufficient funds were allocated to these problems.

In order for me to respond in a meaningful way to the Committee's concern, I am making a distinction between administrative and program implications.

We did discover administrative errors in the type of procurement employed to conduct the project. A Memorandum of Agreement (MOA), rather than a contract, was used to obtain this training program. Because regular procurement processes were avoided, there were no administrative checks and balances to ensure that there was justification for only those services and items required to fulfill the training objectives, that they were purchased at favorable costs, and that the government was protected against real or apparent waste and abuse. The use of MOA'a for procurement type actions are the exception rather than the rule in IHS and, upon examination, mostly have been isolated to the Albuquerque Area Office. We have asked the Office of General Counsel (OGC) to provide overall guidance on the use of MOA's and have ceased using MOAs for procurements pending receipt of the OGC advice (excepting P.L. 86-121 Sanitation Facilities Projects). We have also forwarded to the Office of Inspector General (OIG) information on the alleged use of two forged documents which were involved in the transaction. We do not know if any criminal intent or personal enrichment is involved, but an initial investigation requested by IHS and performed by the Director of Fiscal Services of the Health Resources and Services Administration for the Public Health Service, indicates that no funds were diverted to private use and that all funds were accounted for. Depending on the results of the OIG investigation, appropriate action will certainly be taken.

The testimony and comments at the Hearing questioned the programmatic aspects of the Sunrise Springs Retreat and implied that funds needed for care were diverted to personally benefit IHS employees. I would like to provide information that I believe is necessary to understanding the appropriateness and importance of this activity, even though there were administrative errors.

The Sunsrise Springs Retreat was an IHS/tribal employee training and team building activity that focused on: developing knowledge and skills around wellness strategies; developing team building skills and strategies; and developing community capabilities to initiate and sustain health promotion activities.

Dr. Dougherty, senior health analyst, Division of Health Programs, Office of Technology Assessment (OTA), testified that the top five or six illnesses causing death of Indian patients were "social causes of death or external causes of death. Its not from the natural physiological processes of aging." She stated further, that external causes were a result of " . . . social and economic conditions and resulting psychological conditions from those. There's the high rate of poverty, a very, very, high rate of unemployment among Indians, and that causes hopelessness and despair which can lead to drinking and drug abuse. . ."

We fully agree with Dr. Dougherty. The IHS can do very little about poverty and unemployment, but one way IHS can make a difference is by assisting tribal leaders, and Indian individuals and communities to learn that they have the power to take positive action on those parts of their lives over which they have control. Together, some Indian leaders and IHS staff have begun to experience success in changing Indian community values from high health risk towards health promoting behaviors. In some Indian communities people are taking actions themselves to improve their health status and feelings of self worth, and positive action is accelerating to deal on a community basis with alcohol abuse, child abuse, smoking, and other life-style high risk behaviors that lead to "social or external causes of death."

I have an overiding concern that the Sunrise Springs incident may cast suspicion on all of the IHS health promotion and disease prevention activities.

The concept of health promotion/disease prevention is the fundamental principle upon which the IHS program rests and, represents what I have understood to be the intent of the Congress. For example, in the Snyder Act of 1921, which is the basic authorizing legislation for the IHS program, the Congress directed the Secretary to "expend such sums as Congress may from time to time appropriate for the . . . relief of distress and the conservation of health". The term "conservation of health" seems to be a clear expression that health promotion and disease prevention are fundamental tenets of the IHS program. The Drug Omnibus Bill of 1986 directed the IHS to expend $500,000 of the money appropriated for alcohol treatment for health promotion/disease prevention activities. The 1988 amendments to the Indian Health Care Improvement Act state at section 203 (a) that the "Secretary, acting through the Service, shall provide health promotion and disease prevention services to Indians." In these amendments, the Congress noted that "health promotion and disease prevention will reduce the expenses for medical care of Indians." Of equal importance is that Section 203 specifically provides for training and continuing education for IHS employees, including experiences in health promotion and disease prevention.

In additon to actions by the Congress, the Surgeon General has enunicated the principles of health promotion in the publication entitled "A Healthy Nation". The goals for the nation are all built around health promotion and disease prevention. The medical literature abounds with information attesting to the value of health promotion/disease prevention.

I have more than thirty years experience in academic medicine, private practice in both a University and a military setting, and nearly eight years specifically in public health. I have more than twenty years of experience specifically in Indian affairs, as a tribal council member, volunteer physician in an Urban Indian program, incorporator of Indian programs, the founder of the Association of American Indian Physicians, and a chairman of Congress' Task Force on Health of the American Indian Policy Commission, and have received a number of commendations and awards attesting to my extensive experience. It is my judgement that aside from the administrative mishandling the conceptual model of the Sunrise Springs experience was not only warranted but essential to continued progress toward healthy Indian and Alaska Native people, especially when dealing with alcoholism. An indepth description and rational for the Sunrise Springs Retreat is attached in Exhibit 4.

Testimony was presented that IHS spends only 3 percent of its budget on alcohol problems. This arises, I believe, from the common lack of understanding of the IHS programs. The figures given in the testimony reflect only specific line items in the budget identified as the alcohol program. It is often forgotten that much more care is provided for a given condition than that reflected in certain special emphasis programs.

In Fiscal Year 1989, Congress appropriated $18.7 million authorized by Public Law (P.L.) 99-570 and $31 million for P.L. 94-437 as line items for alcohol and other drug abuse treatment, prevention, and education activities. This totals $49.7 million, which is just under 5 percent of the entire IHS budget, and is most often cited as the amount IHS spends on these activities. The IHS spends, however, an estimated additional $69 million in hospitals and clinics on patients whose primary diagnosis is alcohol or other drug abuse, or other diagnoses in which alcohol or other drug abuse is either the cause or a major contributing factor. These include cirrhosis (almost always caused by alcohol), accidents (over half involving alcohol), and homicides and suicides (over half involving alcohol or other drugs).

All of these are among the leading causes of death among American Indians. In additon to medical treatment, they require assessment, education, referral, counseling, and treatment for alcohol and other drug abuse. More than 20 percent of inpatients and 2 percent of outpatients are treated for conditions in which alcohol or other drug abuse is a causal or contributing factor. Exhibit 5 contains a chart and narrative that conservatively estimates that the IHS is spending 12 percent of its budget on alcohol programs and services to patients with a diagnosis related to alcohol abuse.

HEALTH STATUS INDICATORS

The health status indicators used by IHS to show progress being made in improving health status were described as somewhat misleading in general by Dr. Dougherty and specifically for Pine Ridge by Dr. Nicholson. IHS analyzes and publishes Indian health status data in various ways depending upon the purpose of the report. For a given purpose, we do not believe there are any differences between OTA and IHS in measuring health status.

The IHS Chart Series Book is the major IHS statistical document published annually to show IHS-wide trends going back to 1955, the inception of the IHS. It will be issued in August 1989 under a new name, Trends in Indian Health. For its designated purpose, it aggregates health status indicators which can be misleading since any regional differences are not shown. This problem is clearly illustrated with the wide disparity of infant mortality rates among the IHS Areas. IHS has published various reports which address some Area differences including those in infant mortality and in inpatient utilization; however, IHS has not routinely published a comprehensive report that depicts the regional differences for a full range of key health status

indicators. In order to fill this gap and to focus more attention on the Area variations in health status, IHS plans to begin publishing in 1990 a companion document to Trends in Indian Health called Regional Differences in Indian Health.

We have prepared a series of charts and narratives, Exhibit 6, that address the major points in the OTA testimony, and present some of the IHS initiatives for dealing with the identified problems.

Dr. Nicholson expressed appropriate concern about his observations of infant mortality on the Pine Ridge Reservation. The dramatic improvement in Indian infant mortality rates from over 60 deaths per 1,000 live births in 1955 to approximately 12 deaths per 1,000 live births in 1986, is one of the achievements of which the Indian people can be most proud. However, this achievement is not equally shared by all Indian communities. Our data, though disagreeing with the specifics of Dr. Nicholson's statement, show that the infant mortality rate for residents of the Pine Ridge Service Unit is unacceptably high. Exhibit 7 is a brief report analyzing the available data.

In Exhibit 6, there is a chart and narrative on postneonatal deaths which indicate that more than 57 percent of Indian postneonatal deaths are attributed to causes which the medical system has no proven effective intervention. The IHS, through a contract with the American Academy of Pediatrics (AAP), is currently studying the causes of death among infants who died after the neonatal period in four of the IHS Areas: Aberdeen, Billings, Portland, and Alaska. The AAP has completed one year of the two years study period and the results are not yet available. When they are, the IHS will determine whether any correctable or preventable factors exist and take whatever actions are appropriate and feasible. The Amendments to the Indian Health Care Improvement Act, P.L. 100-713, required that the IHS develop a plan by January 1, 1990 for reducing Infant Mortality to the lower of twelve deaths per 1,000 live births or the rate of infant mortality for the U.S. as a whole.

RESOURCE ALLOCATION

The Committee's concern and the testimoney about funding of IHS programs focused on the impression that resources are not being allocated to areas of greatest need, especially in the Aberdeen Area. It was implied that this occurs because IHS uses a "historical" basis for resources allocation, rather than a more appropriate "health-needs" basis. The historical basis for funding was described as, allocating the same or base amount as last year, adjusted for inflation; therefore, any disparities among areas continue. A health needs basis, however, implies that base funds would be reallocated to areas with the greatest health needs.

The IHS recognizes that disparities exist among Areas and that all the Areas have significant resource deficiencies. During the past ten years, the IHS, with the direction and assistance of the Congress and the concurrence and participation of the tribes, has made significant progress in reducing the funding disparities among the Areas without disruption to the existing health delivery system. The accomplishments have been achieved through the allocation of new funding, and as a last resort, minimal reallocation of base funding.

We believe IHS has been responsive to the message of Indian tribes and the Congress as well as to the needs of good management to reallocate base funding only as a last resort. The political pressure, both tribal and congressional, to protect base funding has been great. For example, the Indian Self-Determination Amendments of 1988, in order to protect contractors' funding levels, effectively eliminates a substantial portion of the IHS, program funding from being a source for redistribution. Reports accompanying the IHS appropriations in recent years have limited reallocation of base funding to three percent in FY 1987 and five percent in FY 1988. In addition, the Indian Health Care Amendments of 1988 require a report to the Congress before any reallocation of base funding over five percent is carried out. Exhibit 8 provides a chart on Redistribution Constraints and a summary analysis of the issue of historical basis funding.

The IHS has devoted extensive efforts to develop and refine resource allocation methods that target resources to those areas with the greatest needs. A major initiative to reduce funding disparities among the Areas occurred in the early 1980's. During FY 1981-1984, the Congress established the equity health care fund and appropriated $32.3 for its implementation. These funds were allocated to the tribes, through the Areas and service units, with the greatest levels of resource deficiency. The equity fund was distributed annually to the most resource deficient tribes in amounts sufficient to raise their funding to the next level until the fund was exhausted. Although the equity funds represented less than two percent of the IHS annual appropriations, the cumulative effect of the fund was dramatic. Newly recognized tribes, which could be 100 percent resource deficient, were important recipients of the equity health care funds. Thus, the equity funds did have the direct effect of elevating the real funding status of the most underfunded tribes.

Following the equity fund, the IHS, in FY 1985 set aside $5 million as a special fund to continue progress in reducing the funding disparities among the Areas and service units. This fund was distributed to those service units and tribes most deficient in resources. Since FY 1985, the IHS greatly expanded and refined the resource allocation process. This process has evolved into a fair, rational and reasonable approach, approved by the tribes and the Congress, for the allocation of resources among both IHS and tribal service units, and among Areas. This system is known as the Resource Allocation Methodology (RAM).

The RAM establishes priorities for funding using comparative scales at two levels:

-- Area Resource Allocation Methodology (ARAM) ranks the Areas
-- Service Unit Resources Allocation Methodology (SURAM) ranks the Service Units

The RAM is based upon four indices of health care needs and problems in Indian communities. These are:

— Population index (active users)
— Services index (inpatient days/outpatient visits)
— Health Status index (Years of Potential Life Lost - YPLL)
— Performance index (total clinical work units - CWUs)

The IHS establishes a fund each year for the application of the RAM. This fund is subdivided into four parts corresponding to the four RAM health care indicies. The funds are then allocated among competing Areas and Service Units based upon the relative comparison of Areas on each of the RAM indicies. The health care indices are based on objective data that are reported and tabulated in a uniform manner for all Areas and Service Units. Those Areas and Service Units that rank highest on each of the health care indices are assigned the highest priority and preference for RAM funds. Attached as Exhibit 9 are three charts and a brief explanation that outline the IHS "Needs-Based" allocation system. These charts show that during the years 1981-1989, the IHS distributed $153 million using various needs-based formulas.

Dr. Nicholson stated that IHS has been unresponsive to the needs of Service units. I can appreciate Dr. Nicholson's frustration and even identify with his perspective. Many years ago, I was a young physician in charge of a program at one of the large Air Force hospitals. I was convinced that the Air Force medical program was a disaster and that the echelons above me were uncaring and perhaps even incompetent. I based my judgement on problems I could see only in my own operation and my seeming inability to move those above me to address these problems. Subsequent experience demonstrated to me that contrary to my strongly held beliefs, there were, in fact, dedicated and competent people running a system that was far more complex and interrelated than I was able to observe from my small and circumscribed vantage point.

Since FY 1981, the various resource allocation processes employed by the IHS has had a significant impact on reducing the funding disparities among the IHS Areas, especially in the Aberdeen Area. The fourth chart and explanation at Exhibit 9 demonstrates that the Aberdeen Area received the fourth highest dollar allocation and the largest percentage increase over their original base under these systems. The Aberdeen Area received the largest percentage increase in clinical funding for the years 1981-1989. The number of physicians in the Aberdeen Area increased at a higher rate than the IHS and the workload per physician declined in the Aberdeen Area compared to an increase for the rest of IHS. This Aberdeen trend is positive. The problems are recognized. The IHS is making improvements, constrained only by the severe budget problems facing the entire country.

Other evidence of progress in Aberdeen is reflected in the fact that during the past 4 years, the Congress has funded the design and/or contruction of two hospitals and four health centers. These projects are the results of the need identified by the IHS Health Facilities Construction Priority System. The additional personnel associated with full staffing of these six facilities will add 548 positions, an increase of 54 percent over the previous employment level (1,048) in the Aberdeen Area. In addition, the Congress has funded a planning study for a third Aberdeen Area hospital (also on the priority List). In funding the six facilities (five in South Dakota and one in North Dakota), the Congress has addressed many of the most urgent needs for improved health care facilities and services in the Aberdeen Area. Additional improvements will shortly come to fruition through the completion of these hospitals and clinic construction projects.

Cooperation with the Committee

I would like now to discuss the charge that the IHS has not cooperated with this Committee as evidenced by our late submission of requested documents in an unorganized manner. As the Committee was informed in the May 12 response (Exhibit 10), the delay arose from the lack of clear definition of what was required by the Committee, the sheer volume of the extensive material required, and our understanding that Committee investigators had, in fact, received most or all of the requested materials during their field investigations. Further, on one occasion, a member of the investigative staff indicated to a member of my staff that the material was not required for the hearing.

When, during my deposition, I learned that this was a problem, I ordered the Area Offices involved to immediately send in all materials they had collected. It was these materials that were delivered to the Committtee the Friday before the hearing. My judgement was that a good faith submission of available materials should be made before the hearing and would demonstrate my commitment to comply with the Committee request. As the above mentioned interim and transmittal memoranda stated, it was our intention to transmit documents to the Committee as soon as they become available to us. There was never any intention not to cooperate.

After the May 15 hearing, I ordered efforts to obtain, review, catalogue and submit the requested material (Exhibit 11). These were submitted to the Committee on Thursday, May 25. I believe they are complete. If not or if there are additional documents the Committee wishes, I will see to it that they are provided expeditiously. A change in IHS procedures has been instituted by which all such future requests from Congressional Committees will be handled through line managers rather than through staff.

This revised procedure was used to respond to the Committee's June 23 request to Dr. Sullivan for information and documents concerning the IHS organization, certain contracting activities, and meetings or conferences involving IHS key managers including HP/DP conferences. On June 30, an action plan was implemented within IHS headquarters (Exhibit 12). And a memo was sent to all Area Offices on July 3 to request the necessary documents (Exhibit 13).

A telephone conversation between Mr. Sam Hirsch of the Committee's staff and Mr. Marsland, Director of Headquarters Operations, IHS, to clarify certain aspects of the Committee's request and to discuss circumstances of document retrieval from Federal Records Centers led to an agreement concerning our response (Exhibit 14). All available documents were transmitted to the Committee on July 20. Documents that are being retrieved from the Federal Records Centers will be provided by September 15.

I received a letter from Mr. Kenneth M. Ballen, Chief Counsel to the Committee, on August 2 that questioned the completeness of our response to the June 23 request. Mr. Hirsch and Mr. Marsland discussed, by telephone, this letter on August 3 resulting in further clarifications and agreements (Exhibit 15). To execute these agreements, additional instructions were sent to the Area Directors on August 4 (Exhibit 16).

As I stated earlier, our intention has been and continues to be one of full cooperation with the Committee. And I believe that the actions described above will demonstrate our committment to cooperating with the Committee.

The final point I want to address is the very serious charge that a witness may have been pressured not to cooperate fully with the Committee. I had early on spoken to my staff about cooperation with the Committee. On May 5, I sent a memorandum that was to be distributed to all IHS employees calling for cooperation (Exhibit 17). After the Committee's expression of concern at the May 15 hearing, I sent another memorandum on May 18 to all IHS employees calling for their cooperation (Exhibit 18). I therefore, remain dismayed as to the allegations that someone had pressured a witness. As I stated in my May 16 letter to you (Exhibit 19), I will take whatever appropriate action is called for if the allegation should turn out to be true though I must say that I remain hopeful that this will turn out to have been a misunderstanding.

As of this moment I have received no information from the Committee which would permit a conclusion as to whether witness tampering has occurred. I respectfully request this information because of the very serious nature of such a charge.

Certainly a correction should be published should the charge turn out not to be correct.

It is my wish that we can go forward from here and that we can both get on with our mutual goal of improving health services to Indian and Alaska Native peoples.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT

BY

EVERETT R. RHOADES, M.D.
DIRECTOR
INDIAN HEALTH SERVICE

BEFORE THE

SELECT COMMITTEE ON INDIAN AFFAIRS
SPECIAL COMMITTEE ON INVESTIGATIONS
UNITED STATES SENATE

MAY 15, 1989

Mr. Chairman and Members of the Committee:

I am Dr. Everett R. Rhoades, Director of the Indian Health Service.

I am pleased to be here today to answer any questions you and your Committee may have on the management of Indian Health programs.

As you know, the Indian Health Services (IHS) is the Federal agency charged with administering the principal health program for American Indians and Alaska Natives.

FOCUS OF INVESTIGATION

It is my hope that these investigations will facilitate the achievement of our mutual goal to continue to raise the health status of American Indian and Alaska Native people to the highest possible level. In that regard, let me assure you that the IHS is fully committed to cooperation with the Special Committee and will assist in every way possible. I have instructed all IHS personnel contacted to cooperate with Committee staff. It is my intention to take whatever steps are appropriate as a result of your investigations to respond expeditiously to assure an effective program.

As long as I have been aware of the existence of IHS, I have heard the accusation that "the IHS is poorly managed." When I came to IHS as its Director, that cloud still hung over the agency. And now, 7 years later, I am hearing once again that the IHS is poorly managed. One possible

explanation for this continuing indictment is that the IHS is in fact badly managed. But gentlemen, I am here to tell you that the management of IHS is exemplary and I believe I can provide the evidence to support that assertion. It is worth noting that IHS is under constant scrutiny and evaluation both internally and externally, and has always not only accepted such scrutiny, but encouraged it. More importantly, under any measure, IHS has held up well to such examination whether it has been undertaken by the Joint Commission on the Accreditation of Healthcare Organizations, Tribal organizations, Office of the Inspector General or other examinations by the Congress. Why then this constant slander against the Agency? I am coming to suspect that it may have attributes of self-fulfilling prophecies - "it is suspected to be true, therefore it is true."

As in any large organization, from time to time problems inevitably arise, whether because of intentional wrong doing or simply because of poor judgment with good intentions. In either case, such incidents are not unique to the IHS. More importantly, where problems have occured, we have initiated action to identify them and to take corrective action where appropriate. Gentlemen, I believe that the assertion that the IHS is badly managed is a cannard that I would like to put to rest today. It is seriously impeding our ability to accomplish our most important assignment - improving the health of Indian people.

Lets look at some of the facts. As I review the specific examples of alleged maladministration brought to my attention by the Congressional investigators, I note that in every case the problem was first identified by IHS or other Departmental agencies and prompt action taken.

For example, in the Fall of 1988, questions arose about improprieties within the Bemidji Area Office. A report by the Inspector General submitted on October 28, 1988, concluded that improprieties had indeed occurred. By January, 1989 I had formally recommended that one official be separated. Subsequently that individual resigned. Given my concern for the rights of employees, I believe that we acted expeditiously.

Another example concerns a management problem in the IHS Oklahoma City Area Office which became apparent in the spring of 1988. An IHS Associate Director and an Executive Officer from another area were immediately reassigned to the Oklahoma City Area to provide leadership and correct management deficiencies. These actions included a major effort to correct problems in the contract area involving analyses by IHS and PHS contract specialists, the development of a corrective action plan and the assignment of a team of contract specialists to assist in implementing the plan.

PROGRAM ACHIEVEMENTS

Measured by any standards, the IHS has achieved spectacular progress in raising the health status of the American Indians and Alaska Natives.

Mr. Chairman, in the short time I have been Director of IHS, the overall mortality rate for American Indians and Alaska Natives fell by 7.5 percent while that for the U.S. fell only 2.2 percent; that for pneumonia and influenza fell by 23 percent for American Indians and Alaska Natives while that for the U.S. actually increased by 24 percent; the death rate for alcoholism among American Indians and Alaska Natives fell by 22 percent while that for the U.S. was unchanged; the mortality rate for injuries among American Indians and Alaska Natives fell by 16 percent compared to only 4 percent for the U.S.; the mortality rate for heart disease of American Indans and Alaska Natives is lower than that for the U.S. as is that for cancer.

These impressive accomplishments have been accompanied by a declining rate of hospitalization and an increase of 23 percent in ambulatory visits. The latter figure reflects the addition of nearly one million annual ambulatory visits being provided for American Indians and Alaska Natives. Can anyone reasonably conclude that these unparalleled accomplishments could have been achieved through bad management?

The IHS will continue to focus on quality assurance, community based comprehensive care and the commitment to support activities that reduce health risk factors as well as treat diseases.

This focus reflects new directions that have been brought about by earlier successes. There has been a gratifying increase in the numbers of physicians who are either certified by the appropriate board or eligible

for certification; 93 percent of the hospitals are now accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO); in the past 3 years the percent of IHS health centers accredited by the JCAHO has increased from 48 percent to 68 percent.

For years, the IHS has been on the leading edge in promoting fitness, wellness, nutrition and emphasis on health promotion and disease prevention activities.

Section 203 of the Indian Health Care Amendments of 1988, Public Law 100-713, states that: "The Congress finds that health promotion and disease prevention activities will - (1) improve the health and well being of Indians, and (2) reduce the expenses for medical care of Indians,". In FY 1988 ten grants were awarded to assist Indian communities in the development of programs and activities to address the prevention of chemical dependencies, diabetes, heart disease, fetal alcohol syndrome, and other preventable diseases heavily influencing health status in American Indian and Alaska Native communities. Examples of successful projects include: The Shiprock Youth Center project in New Mexico which is directed at health awareness, fitness and counseling of Indian youth; the Copper River Native Association project in Alaska which is directed at determining the rate of cancer occurence and explaining means of reducing or preventing such occurrence; and the Zuni Wellness Center and Health Promotion project in New Mexico, a comprehensive health promotion effort.

The IHS has developed a draft National Mental Health Plan for Native Americans. This plan reemphasizes IHS' present policy of giving high priority for services to children and their families. The IHS Mental Health Branch has also created a mobile national team of 3 members to provide consultation to tribes and service units on the prevention of family violence, including child abuse and neglect. This team is located in Albuquerque, New Mexico . The IHS presently utilizes mental health standards that were developed in 1986 and approved in 1987. The Mental Health Program Review process requires that each Area program be reviewed every other year, with reviews of 2-3 mental health programs during each Area visit. Through the review process recommendations are made for program management and service improvements.

During the past three years the IHS has planned, designed and constructed 9 new and replacement hospitals including a major medical center, 8 health centers and 516 staff quarters. In addition, major repair and renovation work has been accomplished at 35 IHS health care facilities. The two regional youth treatment centers mentioned previously have been made operational as a result of this program.

MANAGEMENT ACCOMPLISHMENTS AND INITIATIVES

In order to more efficiently manage resources, the IHS has completed an evaluation of the current use of a fiscal intermediary to operate a nationwide claims processing system. An independent evaluation has concluded that the use of the fiscal intermediary has increased efficiency

in processing contract health services claims. For example, it is paying over 85 percent of the claims within 28 days with less than a five percent error rate. In addition, the IHS implemented a payment policy based upon Medicare Prospective Payment System (PPS) Diagnosis Related Groups (DRG) for inpatient care as a cost containment measure. This policy has resulted in a savings of $2 million in FY 1988. Annual savings are projected to be $4 million for FY 1989, permitting the IHS to provide more services.

The PHS has recently issued a report indicating we have made significant improvements to the identification, billing, tracking, and collection of Medicare and Medicaid claims since 1983. These improvements are evidenced by the fact that the level of receivables and related collections have greatly increased over the past four years. Annual receivables have increased from approximately $31 million in FY 1984 to $71 million in FY 1988. Along with this increase in receivables, collections have increased from approximately $27 million in FY 1984 to $66 million in FY 1988.

The development of information management systems continues to be a major priority of the IHS. During FY 1989 the Resource and Patient Management System was enhanced by the development of additional components which will automate the medical and administrative records. These activities will increase both quality of care and administrative efficiencies through timely feedback mechanisms available in automation technology. The pioneering work of IHS in automation systems has been adopted in other agencies.

IHS has developed a national accountability system known as the Community Health Representatives Information System (CHRIS II) and all Tribal '638' Contractors (about 250 Tribes) will be implementing this information system in July 1989. A national test of nearly 3.5 million services in health care and health promotion/disease prevention were provided by 1411 CHRs at an average cost of $7.49 per service.

The elevation of the IHS, on January 4, 1988, has significally expanded the management responsiblilities of the IHS. With the additional duties and responsibilities inherent in such a reorganization, there has been a transitional period.

Prior to elevation, the Office of the Administrator, HRSA appointed contracting officers and provided oversight for IHS contracting activities. With elevation, IHS assumed these responsibilities and has taken actions building upon HRSA's record which give IHS an excellent contracting program. IHS makes more awards - 2,400 contracts and 303,000 purchase orders in Fiscal Year 1988 - than any other PHS agency. These awards total $461 million in FY 1988, an amount which is exceeded only by National Institute of Health (NIH) among the PHS agencies. Also, IHS has an unusually complex contracting program because of the unique aspects of contracting pursuant to P.L. 93-638, Contract Health Care, and the Buy Indian Act.

In its report on Fiscal Year 1988 contracting issued April 1989, PHS found IHS performance to compare favorably with the other PHS agencies in both contract awards and purchase orders. It is noteworthy that the IHS rating equaled that of NIH which is the other large contracting agency within PHS. Two other recent PHS reports on IHS supply and equipment purchases and construction and Architect/Engineering contracting have also reflected strong performance by IHS. Also, audits by the Office of Inspector General and outside auditors of P.L. 93-638 awards reflect favorably on the performance of IHS as well as tribal contractors. During FY 1988 the Department received 193 audit reports covering $160 million in contract awards by IHS. Of this only $371,000 or .23% was questioned.

It is significant that we have accomplished this record with our staff processing 26.1 Contract Actions per staff person which is a much larger workload than most of the other PHS agencies.

Actions which we have taken since elevation to ensure that we maintain a strong contracting function include the following:

1. The establishment of a second contract division to emphasize policy and oversight.

2. The implementation of a strong contract compliance review function.

3. We are near completion of an in-depth study of IHS contract health care, which is expected to identify areas for improvement.

4. A study has been completed and a reporting system implemented to prevent excessive advance payments under P.L. 93-638 Contracts

5. The award of a contract to the Logistics Management Institute, a federally funded R&D center, to study the IHS supply acquisition and distribution system. This study, which is nearing completion, will result in improved economies and management control.

As a result of Agency-level elevation, effectiveness of IHS operations has been increased by the creation of a Program Integrity and Ethics Staff, and the establishment of the Internal Control Review Programs' Branch.

The Internal Control Review Staff initiates risk assessment through specific reviews of activities at highest risk, identifies weakness and designs corrective action plans. Internal control reviews will be conducted in all eleven IHS Area Offices covering administrative functions carried out in the Area Office.

The Program Integrity and Ethics Staff coordinates investigations and responds to allegations of impropriety, mismanagement of resources, abuse of authority and Standards of Conduct, develops and evaluates the agency's Automated Information Security Program, and makes recommendations for corrective actions. The high priority given by IHS to this function is evidenced by the fact that the only other PHS agency, other than IHS, with an ethics office is FDA. It is my understanding that NIH is now establishing one.

The Division of Personnel Management was established to provide personnel services to headquarters employees and to develop personnel policies, procedures, and programs for IHS. Emphasis is being placed in developing programs to enhance our managerial capabilities. The Office is developing a personnel management intern program to attract the best and the brightest Indian college graduates to be our future leaders. A mid-level management development program is being created to sharpen the managerial skills and abilities of our mid-level managers who will be our top executives in the near future. We are reviewing the strengths and weaknesses of our top executives with a view to developing training plans for correcting any deficiencies noted. The Division also has an employee relations function which reviews complaints, grievances and Congressional inquiries and recommends appropriate corrective action to management. The HHS Regional Personnel Offices are responsible for internal control and technical reviews of our IHS personnel offices in the field.

In summary, while we welcome scrutiny and view complaints, criticisms and the identification of management problems with the utmost seriousness, mechanisms are in place to identify such problems and to take corrective action where appropriate.

Moreover, I believe that any problems should be viewed in the context of the overall achievements I have described. Individual cases of fraud, abuse or mismanagement should not adversely reflect, nor are they characteristic of the dedicated, professional efforts of an IHS staff of over 11,000.

In my view, this staff provides within the resources made available, an effective, innovative and well managed program of health care for Indian people that has been recognized by health professionals as a "model" for other health care delivery systems. In spite of any problems along the way, IHS is a program that works.

Mr. Chairman I submit that the decrease in infant mortality rate; the increasing longevity of Indian people; the achievement of an age adjusted death rate for Indians, no greater than that for the rest of the United States; the decrease in maternal mortality rate; the decrease in mortality from alcoholism of approximately 22 per cent can only have been achieved through strong adminstrative and program management. Mr Chairman, at this time, I will be pleased to try to answer any questions which you or other members of the committee may have.

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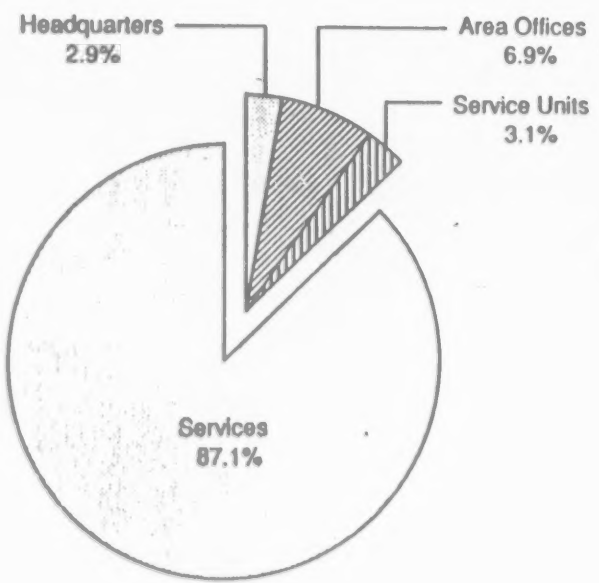
IHS Administrative Costs Percentages Compared to Total IHS Costs and Compared with other Health Systems



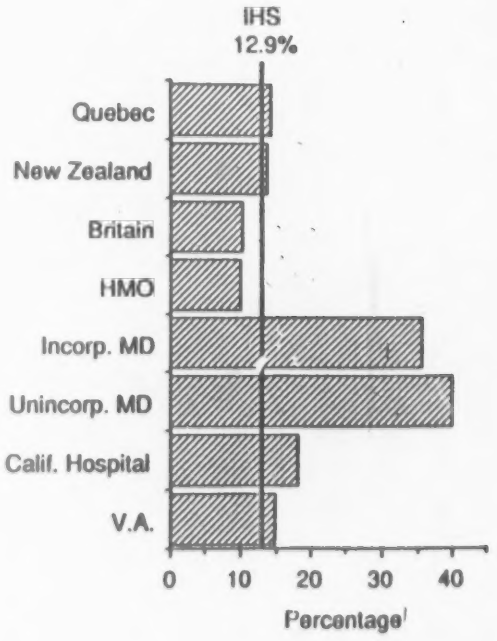


Exhibit #1

Administrative Costs

Charts: IHS Administrative Cost Percentages Compared to Total IHS Costs and Compared with other Health Systems

Claim: How much is IHS spending in overhead? Are administrative costs excessive in the IHS?

Source: Results were taken from an in-house IHS study distributed in July,1988 entitled *A Report on the Adminstrative Resource Requirements of the Indian Health Service*. This report was completed prior to the elevation of the IHS to agency status. The report has not yet been updated to reflect some administrative changes that accompanied elevation.

The report is based upon expenditure data obtained from the Health Accounting System for FY 1986. The analyis is based upon the expenditures for administrative cost centers and functions without regard to the budget category from which these costs were charged. This is more accurate than using costs charged to Direct Operations (program management) alone since some administrative charges are paid from most budget categories. The reported administrative charges were also subjected to field validation and verification at area offices.

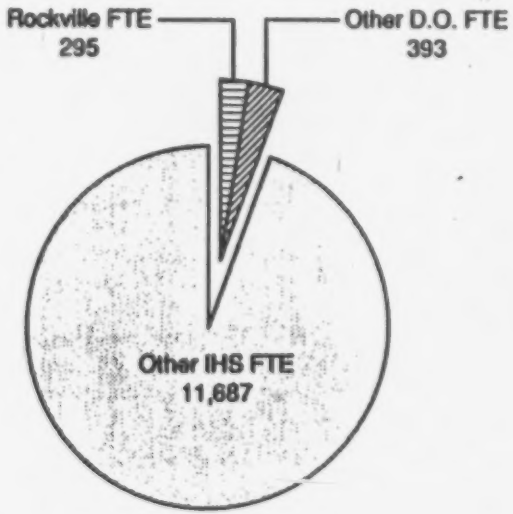
The administrative percentages for other health care systems were taken from: *Dugan, H. S., Administrative Costs of Health Care Systems Johns Hopkins Center on Aging, 1986 (Agreement #86H00225901D)*

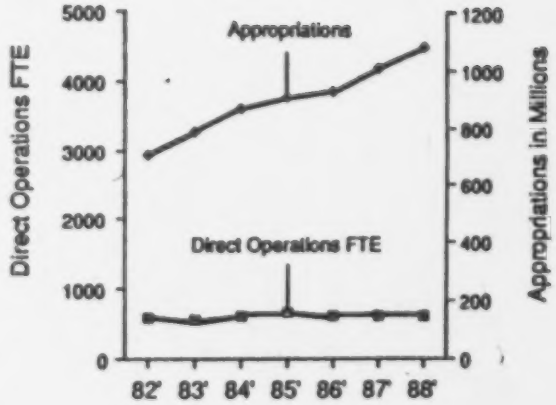
Analysis:

- Approximately 12.9 percent of IHS funding is charged to administrative functions.
- Total IHS administrative costs are charged variously at HQ, area offices, and SU's.
- The comparison of IHS administrative costs with other systems is problematic (particularly with respect to MD practices). However, the crude comparisons in the chart show that IHS administrative costs are in alignment with other systems and appear reasonable.

Conclusion: The IHS can identify its administrative costs. Administrative costs in the IHS compare favorably with those in other health care systems.

Comparison of IHS Direct Operations Administrative FTE With Total IHS FTE and With Increased Appropriations Since 1982





Administrative Staff

Charts: Comparison of IHS Direct Operations Administrative FTE With Total IHS FTE and With Increased Appropriations Since 1982

Claim: Is the number of administrative staff excessive in the IHS?

Source: FY 1989 Financial Management and Personnel data systems were used to project the number of FTEs in the Direct Operations budget category (program management) and total federal FTEs in IHS during fiscal year 1989. These data do include certain changes in staff associated with the elevation of the IHS to agency status. (PIE chart)

Appropriations totals since 1982 are taken from the IHS budget office. Direct Operations FTE totals since 1982 were taken from the 1990 IHS budget justification. (LINE chart)

Analysis:

- The 295 FTE in Rockville represent 2.4 percent of all federal FTE in the IHS.
- The 688 FTE in Direct Operations (program management) represents 5.5 percent of all federal FTE in the IHS.
- In addition to administering IHS operated programs, the Direct Operations FTE also perform some oversight functions for tribal contractors which were funded at over $200 million in 1988
- The number of Direct Operations FTE has remained relative constant while the IHS appropriation has increased 35.8% since 1982.
- Caution: Direct Operations FTE are largely at HQ and area offices. They perform a combination of system-wide management and direct support (personnel, finance, purchasing, etc) of field operations. Because Direct Operations FTE does not include certain other administrative staff located at SUs and contractors, it can not be concluded that the numbers presented in these charts represent the complete count of all administrative staff for IHS programs.

Conclusion: The IHS can identify staffing at Rockville. The mixture system-wide and direct field support performed by Direct Operations FTE make sweeping statements about IHS overhead very difficult. Nevertheless, program management staff is low relative to total staffing and has remained stable while size (funding) of IHS programs has increased.

Exhibit #2

SUBJECT: QUALITY MANAGEMENT INITIATIVE QMI

The QMI is the Number 1 IHS objective for the coming year. It is based on the need to take certain corrective actions with respect to IHS' administrative management systems. The IHS plans to undertake a comprehensive and intensive review of its administrative management systems and to develop a plan of action for strengthening the administrative capability of the Agency. The objective of the plan is to improve the chain of command and ensure development of an administrative staff that operates effectively within the law and in compliance with IHS policies, and guidelines. Organizational problems will be remedied and administrative responsiveness will be improved. The focus of this initiative will be in the Office of Administration and Management, but program managers at Headquarters and in the IHS Area Offices also will be involved.

SUBJECT: QUALITY MANAGEMENT INITIATIVE TEAM

Responsibility for completing this plan is assigned to the Director of Headquarters Operations. He has been given the authority and support necessary to ensure a successful effort. A special team of key IHS personnel has been assembled to staff this effort. They have been placed on detail, reporting to the QMI leader. The team members possess expertise in the areas of program planning, evaluation, program management, management analysis, and financial management. The Team meets daily and is identifying short and long-range issues.

SUBJECT: TWO MANAGEMENT CONSULTANT FIRMS

The Logistics Management Institute and the firm of Scanlon and Hastings have been engaged to develop a strategic plan for accomplishing the QMI. The plan will consist of the following four principal components:

1. a execution strategy - the objectives of the QMI will be described, the roles of key participants will be defined, and implementing initiatives will be recommended;

2. a work plan for reviewing new agency responsibilities, their relationship to IHS strategic objectives, and their impact on the roles and responsibilities of Headquarters and the Area Offices;

3. a work plan for evaluating management systems within IHS and a prioritized list of improvement projects; and

4. a schedule and budget for the entire initiative.

SUBJECT: FEDERAL MANAGERS FINANCIAL INTEGRITY ACT (FMFIA)

The QMI team initiated a comprehensive review of IHS compliance with the FMFIA. The team is charged with instituting all necessary measures to ensure that IHS managers comply fully with the basic responsibilities of Federal officials. To this end the team is proceeding to accomplish the following tasks:

1. Review respective functions of HRSA and IHS fiscal services relative to FMFIA. Focus upon internal control and ensure that necessary accounting and administrative systems are in place;

2. Assess the availability of formal FMFIA documentation and establish all necessary guidance and procedures to ensure that managers assume applicable FMFIA responsibilities; and

3. Evaluate the responsibilities and coordination roles of IHS managers for compliance with FMFIA and enforce necessary standards of performance.

Specific action items and due dates are as follows:

Division of Resource Management — Due 8/31

(1) Identify and list functions that entail some level of financial responsibility.

Division of Management Policy — Due 12/31

(2) Written policies and procedures for IHS administrative operations will be completed. A format has been designed, but sections of the IHS Manual have not been completed. This may be accomplished most efficiently by contracting-out.

Associate Director/OAM — Due 9/30
Division of Personnel Management

(3) Person(s) responsible for performing the functions identified in (1) will be assigned responsibilities. These responsibilities should be described in detail in position descriptions, and reflected in annual performance plans.

Division of Management Policy — Due 8/31
Division of Resource Management

(4) An annual review plan will be prepared. The plan will address timing and scope of reviews for internal control reviews and reviews of the master accounting system.

Division of Management Policy — Due 8/31
Division of Resource Management

(5) How reviews in (4) will be coordinated between HRSA, IHS Headquarters, and IHS Area Offices will be reflected in the review plan.

Division of Resource Management — Due 9/30

(6) A cross-servicing agreement will be written specifically listing functions to be performed for IHS by the HRSA/Division of Fiscal Services.

Associate Director/OAM
Division of Resource Management — Due 9/30

(7) A monitoring plan will be prepared to ensure that activities listed in (6) are performed satisfactorily.

Division of Resource Management — Due 12/31

(8) A cost comparison analysis of services provided by HRSA verses same services provided by IHS will be completed.

SUBJECT: RESOLUTION OF OUTSTANDING INSPECTOR GENERAL HOTLINE CASES

The IHS has made a concerted effort to cooperate fully with the Office of Inspector General (OIG). Towards this end, our staff has held regular meetings: (1) to discuss ongoing and planned investigations; and (2) to incorporate advice and counsel offered by the Inspector General. To address critical concerns expressed about IHS' responsiveness, the lead for follow-up and resolution of outstanding IG Hotline cases has been transferred to the Office of the Director. Meetings have been held with PHS Hotline representatives to clarify processes for the expeditious resolution of these cases and the IHS has set due dates.

SUBJECT: IHS MANAGEMENT TRACKING SYSTEM

This tracking system will provide a systematic process that will enable the Director, IHS, to have immediate access to the status of all (OIG) reports, General Accounting Office reports, Hot Line Cases, and Internal Control Reviews. Once instituted the tracking system would accomplish the following: (1) identify report findings; e.g. internal control weaknesses, hotline complaints, or requests for specific investigations; and (2) provide the status of corrective action plans. The tracking system could be expanded to include various other types of reports.

A series of meetings are planned to address software, equipment, and maintenance needs and systems costs. Our goal is to have the tracking system in place by October 1, 1989. The information produced will do much to improve IHS responsiveness.

SUBJECT: QMI STEERING COMMITTEE

A steering committee, with the following top-level managers as members, has been formed to provide advice and counsel:

Dr. Everett Rhoades, (Chairman)
Director, Indian Health Service

Wilford J. Forbush
Deputy Assistant Secretary for Health Operations and
Director, Office of Management, OASH

John H. Kelso
Acting Administrator, HRSA

George Hardy, M.D.
Acting Deputy Director, CDC

David Mischel
Office of the Assistant Secretary for Personnel

Gerald H. Ivey
Director, Alaska Native Health Area Office, IHS

The Steering Committee met on Friday, July 28. The next Steering Committee meeting is scheduled for August 31 at which time the workplan and actions taken to date will be reviewed. Mr. Forbush will present a management taxonomy and assessment of administrative oversight from the OASH perspective.

SUBJECT: HUMAN RESOURCES DEVELOPMENT

A plan will be prepared to describe how resources and training efforts will be directed towards improving managerial competence and administrative responsibility and to redefined position "standards of performance." Emphasis will be placed on professional ethics in IHS Service Units, Area Offices, and at Headquarters.

Immediate Action Completed or Pending:

By	Action Items
4/27/89	Letter to all voucher auditors offering strong support from Director, IHS if they experience any reprisals for properly doing their jbos.
5/29/89	Mr. Tom Shoe, Director, Division of Grants and Contracts, ORM/OASH assigned as Acting Director of new Division of Contracts and Grants Policy, IHS.
7/10/89	Special General Memorandum - 89-2, Preapproval audit by HRSA Division of Fiscal Services of all Area Director travel claims submitted for reimbursement. Post-approval audit by HRSA, Division of Fiscal Services of all travel by Area key staff.
8/1/89	Deputy Director and Quality Management contractors meet with IHS Area Directors in an executive session to explore findings and perceptions and to involve Area Directors in the process of making immediate changes to improve managerial behavior and to plan for intermediate- and long-term (2-3 yrs.) changes.
8/2/89	A 1989-1991 Workplan for Ethics and Integrity Staff is to be completed.
8/11/89	A 1989-1991 Schedule of Executive Management Reviews of Area Offices is to be completed. A new review structure will focus on the following areas: managerial competence, managerial responsibility, and professional ethics of Area Directors and their immediate staff. A team including the Deputy Director, Associate Director OHP, and Associate Director OAM will conduct the reviews. Objective: To initiate a rapid change in the Area managerial culture by using existing internal control review information, other administrative review responses, program review reports; and personal interviews.
8/20/89	Complete actions to provide urgently needed strength to OAM and have immediate action steps in place.
8/25/89	A short-term action plan for the QMI team will be completed. The plan will include due dates and outcome objectives.

8/28/89	A draft report by the outside contractor on recommended short and long-term corrections and managerial improvements, including strategies, will be completed.
8/31/89	The OASH will completed the management taxonomy and provide rapid results of their assessment of administrative oversight activities.
8/31/89	The steering committee will review actions and plans to date and make recommendations for the immediate future.
9/30/89	An assessment of all internal control functions, administrative oversight functions, and programmatic oversigh functions will be made to determine feedback required for monitoring by IHS headquarters.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Indian Health Service

Memorandu

Date JUL -6 1989

From Director

Subject Quality Management Plan

To Director of Headquarters Operations

Recent reports of the Senate Investigative Committee and the Inspector General have brought to my attention the need for certain corrections in the administrative management systems of the Indian Health Service (IHS).

I am directing you to undertake a comprehensive and intensive review and to develop a plan of action for strengthening the administrative capability of the Agency. The objective of this plan is to improve the chain of command and assure an administrative staff that operates effectively within the laws, policies, and guidelines of the IHS while recognizing the need t continue our decentralized system. The latter of course require a strong and effective Area level management team. The delegations of authority must be in place and clearly understood by all. Our organization must be as responsive administratively as it is medically and programmatically.

I intend to remedy any structural problems, to identify barriers to excellent management throughout IHS and to correct each one.

You are to develop a plan by September 30 that includes the management objectives, strategies for accomplishment, plans and actions required, procedures for improving performance, and a timetable and tracking system. This plan should be comprehensive and therefore, will require actions that will extend into several months. However, I wish to have it developed so that the most urgent needs of the Agency are addressed within the next 6 months.

I emphasize the seriousness of this assignment. It is of highest priority and requires attention of all IHS managers. You may use any resources that you need to assist you in completing it, including IHS staff and outside consultants.

Any study team that you assemble is to work closely with the staff OASH offices and with staff in the Office of the Inspector General. These offices are to be kept fully informed of our progress and to understand that I welcome and solicit their advice.

Everett R. Rhoades, M.D.
Assistant Surgeon General

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Indian Health Service

Memorandum

Date · JUL 14 1989

From Director of Headquarters Operations

Subject Quality Management Initiative

To Area Directors
Associate Directors

This is to inform you that Dr. Rhoades has directed me to undertake a comprehensive and intensive review and to develop a plan of action for strengthening the administrative capability of the Indian Health Service (IHS).

The objective of this initiative is to improve the chain of command and assure an administrative staff that operates effectively within the laws, policies and guidelines of IHS while recognizing the need to continue our decentralized system. The latter of course requires a strong and effective Area level management team. The outcome of this initiative is to assure that we have an organization as responsive administratively as it is medically and programmatically.

The plan for this initiative is due to Dr. Rhoades on Sepetember 30, 1989. It will include management objectives, strategies for accomplishment, plans and actions required, procedures for improving performance, and a timetable and tracking system. The comprehensive nature of this plan will require actions that will extend into several months. The most urgent needs of the Agency are to be addressed within the next six months.

Dr. Rhoades has asked representatives of the Office of the Secretary and the Office of the Assistant Secretary for Health and one Area Director to serve on a steering committee to provide direction and advice to this effort.

I have asked Mary Lou Andersen to serve as the project director for this initiative. She will work with a small group of IHS headquarters staff to manage this activity and coordinate the efforts of IHS staff as well as those of outside consultants. At this time we have retained the services of two firms, LMI and Scanlon and Hastings, to provide the necessary technical assistance to the workplan development. They may be contacting you or your staff during the next few weeks.

Page 2 - Area Directors/Associate Directors

I am asking you to give your full support to this effort and to the people who are working on it. It is of the highest priority and requires the attention of all IHS managers.

Please feel free to call me or Mary Lou Andersen at 443-3921 if you have any questions.

Robert A. Marsland

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Indian Health Service

Memorandum

Date JUL 28 1989

From Director of Headquarters Operations

Subject Indian Health Service Administrative Management

To Director, Division of Audits, Office of Inspector General

In recent meetings with members of your staff, I discussed actions taken by the Indian Health Service (IHS) to improve our Administrative Management system and practices and our communications with your office.

At this time, I am providing you with copies of five documents relating to actions we have taken to improve our performance in the area of Administrative Management. These documents include the following:

1) a memorandum from the Director, IHS to me regarding development of a quality management plan;

2) my memorandum informing the Area and Associate Directors of the Quality Management Initiative;

3) a work statement for our consultants, Scanlon & Hastings, who will assist the IHS develop a strategic plan for designing and implementing a management improvement initiative;

4) my note to the Director reporting progress of the Management Improvement Plan;

5) a status report from the Deputy Associate Director, Office of Administration and Management to me regarding improvement of the IHS response system for issues raised by the Office of Inspector General.

I will, of course, continue to keep you informed of our progress.

Robert A. Marsland
Assistant Surgeon General

Attachments

cc:
Director

WORK STATEMENT

A STRATEGIC PLAN FOR DESIGNING AND IMPLEMENTING A MANAGEMENT IMPROVEMENT INITIATIVE FOR THE INDIAN HEALTH SERVICE

Background

In January 1988, the Indian Health Service (IHS) was elevated to agency status in the Public Health Service to better fulfill its mission to serve the health needs of American Indians and Alaska Natives. There was no comprehensive strategic organizational analysis to accompany the elevation. Only a few organizational changes – those necessary for immediate operations – were implemented. Since its elevation, IHS has been under intense scrutiny by the Congress, and there have been indications that accountability and management control throughout its management structure needs strengthening.

IHS intends to undertake in the fall of 1989 a long-term Management Improvement Initiative to reassess and strengthen the roles, responsibilities, and management systems of its Headquarters and Area Offices. The initiative is expected to have the following major objectives:

(1) To define and realign, if necessary, the roles and responsibilities at all levels of IHS, with particular attention to the relationship between IHS headquarters, the Area Offices, and the tribes they support;

(2) To immediately improve the accountability and responsiveness of IHS offices, staff, and contract service providers, with particular attention to potential fraud and abuse violations; and

(3) To design and implement effective management systems – with information systems to support them – throughout the agency.

Work Plan

The purpose of this project is to develop a strategic plan for accomplishing its Management Improvement Initiative. The plan will consist of four principal components:

1. *An execution strategy.* The objectives of the Management Improvement Initiative will be described; the roles of key

participants (e.g., the IHS Steering Committee, the IHS Director, IHS staff support) defined; and strategies for communicating with various internal and external constituencies, designing new administrative mechanisms, and implementing initiatives shall be recommended.

2. *A work plan for reviewing new agency responsibilities, their relationship to IHS strategic objectives, and their impact on the roles and responsibilities of Headquarters and the Area Offices.* A strategy to be used by IHS in assessing its responsibilities as a separate agency of the PHS and in identifying how to redefine the headquarters/Area Office responsibilities shall be recommended. A key focus of the work plan shall be the authorities, skills, knowledge, and abilities that will be needed at the Area Offices under their role and organizational relationship with IHS headquarters.

3. *A work plan for evaluating management systems, within IHS and a prioritized list of improvement projects.* A strategy to be used by IHS in evaluating all key management systems shall be recommended. A prioritized series of short- and long-term projects needed to achieve the objectives of the Management Improvement Initiative shall be identified and described with projects that pertain to fraud and abuse violations given the highest priorities. Short-term projects will be those which entail relatively simple policy changes and can be implemented within nine to twelve months. Long-term projects will be those that require changes in attitudes and culture. Each project description shall include a statement of purpose, a project schedule, a list of products, and estimated workhour and travel requirements.

4. *A schedule and budget for the entire Initiative.* Time schedules and budgets for the entire Management Improvement Initiative shall be recommended.

Personnel

Anne Hastings will manage the development of the plan. Dr. Hastings will be assisted by Larry Beyna.

Schedule

The project will begin on July 12, 1989. A draft of the Strategic Plan for the

Management Improvement Initiative will be submitted to LMI no later than August 14.

Budget

The Strategic Plan will be prepared for a fixed price of $24,999. This amount includes one trip to Portland, Oregon.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Indian Health Service

Memorandum

Date JUL 28 1989

From Director of Headquarters Operations

Subject Progress Report - Management Improvement Plan

To Director

This report summarizes progress to date on the inititative that you directed me to undertake on July 6.

We cancelled the scheduled Executive Officers meeting planned for Albuquerque during July 10-12. The press of business to answer the Senate Investigations Committee requests required both Area Office and Headquarters staff be available to meet this demand.

ORGANIZATIONAL STRUCTURE:

I have established two teams of IHS senior staff to report to me and to be responsible for: 1) completing and tracking IG action items, including hot line complaints, for the IG; and 2) developing and implementing a Management Improvement Plan (MIP). Bob McSwain will head the "IG team" and will be assisted by Cliff Wiggins and Phyllis Eddy. Mary Lou Andersen will head the MIP group assisted by Athena Schoening, Ron Hernandez, and Debbie Melton.

We have secured the services of two consulting firms, LMI and Scanlon & Hastings. The scope of work requires a completed workplan for the MIP by 8/30/89.

EXTERNAL RELATIONS:

Bob McSwain, Bill Pearson, and Mary Lou Andersen accompanied me to brief IG representatives on IHS plans to correct real and perceived deficiencies. The discussion raised the issue of Agency compliance with the Financial Managers' Financial Integrity Act (FMFIA), a plan to resolve hot line complaints, a need to find a mechanism to negotiate policy differences (size of hospitals), and a desire for improved communications and assistance.

Similar briefings have been held with Bill Forbush.

ACCOMPLISHMENTS:

Both consulting firms have begun work. LMI has met with you to discuss your participation at the upcoming CAAD and has met with Mr. Singyke to plan the agenda and dynamics of the first day executive session with the Area Directors. This is a critical session and a critical time for the

success of this initiative. The script for the interview that will be video taped on 7/27/89 is ready for your review today 7/21/89. The consultants will meet with you at 8:00 a.m. on Monday to discuss and provide some thinking points for use later during the taping.

Staff has analyzed the past IG and GAO reports for common problem areas. There are a lack of measurable criteria for performance in most functions; no systematic review procedures; unsatisfactory timeliness and responsiveness, including the closeout of completed issues such as contracts; no manuals for use by staff; no working procedures that include internal controls; and lack of coordination with other parties.

Priority consideration is being given to Agency compliance with the FMFIA. Not only is this prominent in the IG discussion, but it is legislation and OMB requirements that form the structure of fiscal management in an agency. To date, the team has researched the law, circulars, and guidance; begun an organizational and functional analysis of the current IHS implementation; and plans to complete a requirements analysis next week. There are some inadequacies surfacing even at this early date. Any measures requiring correction will have such a plan immediately.

Human Resources Development planning will be undertaken concurrently. Background materials are being collected. The interested parties; i.e., LaRose, Robertson, and Gerber (Training branch, OHPRD, and HQ West), will convene the week of August 14 to begin developing this action step.

IN PROCESS:

We have three additional actions underway:

1. Develop a management plan for the administrative and management reviews in the Area Offices.

2. Revise delegations of authority structure to reflect the chain of command and to train appropriate Area staff to implement change.

3. Examine Headquarters communications to the field and make recommendations for improvements.

In addition, I am working on the charge to the teams. I expect to have it for you by next week.

Robert A. Marsland
Assistant Surgeon General

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Indian Health Service

Memorandum

Date JUL 28 1989

From Deputy Associate Director,
Office of Administration and Management

Subject Special Initiatives Progress Report

To Director of Headquarters Operations

A plan to improve the Indian Health Service (IHS) response to the initiatives of the Office of Inspector General (OIG) has been developed. It includes the documentation of system descriptions for the IHS-OIG relationship and the related IHS internal systems. Evaluations of the IHS hotline process and our system designed to comply with requirements of the OIG audit process have been scheduled.

First phase documents requested by the Special Senate Investigating Committee, in their letter of June 23 to Secretary Sullivan, were delivered on Thursday, July 20. Those to be included in the second phase are scheduled for delivery to the Senate by September 15.

A memorandum to the Associate and Area Directors concerning submission requirements for the second phase and the September 15th delivery date is being prepared for your signature.

Robert C. McSwain

IHS-OIG RESPONSE SYSTEM

PHASE I:

A. Office of Investigations:

1. Develop Process Description of OIG (Hotline) System - How the stand OIG-Agency interface works. (8/4/89)

   Assigned to: P. Eddy

2. Develop Process Description of the current handling of OIG Hotlines the Indian Health Service. (8/4/89)

   Assigned to: P. Eddy

3. Evaluate the IHS response mechanism for system failure/improvement. Formal description of total system, incuding coordination/clearance points and involvement of Area Offices. (9/10/89)

   Assigned to: C. Wiggins

5. Formulate special "backlog clean-up" protocol, e.g., what cases, status of cases, who is to staff the cases, who works with the OIG, etc. (8/11/89)

   Assigned to: P. Eddy

6. Formulate policy (Circular, SGM or Manual Issuance) on the function authorities, clearances, time frames and responsibilities associate with the IHS-OIG Hotline complaints. (9/8/89)

   Assigned to: B. McSwain, C. Wiggins, P. Eddy

B. Office of Audit:

1. Develop Process Description of OIG Audit and Reporting System - How the standard OIG-Agency interface works. (8/11/89)

   Assigned to: P. Eddy

2. Develop Process Description of the current handling of the OIG Audi and Reports by the Indian Health Service. (8/11/89)

   Assigned to: P. Eddy

3. Evaluate the IHS response mechanism for system failure/improvement Formal description of total system including coordination/clearanc points and involvement of Headquarters Offices and Area Office. (9/1/89)

Assigned to: C. Wiggins

4. Establish baseline of OIG Audit/Report over past five years. Curr Corrective Action Plan requirements. Ongoing audits. Planned audi Regular audit schedule. (9/1/89)

Assigned to: C. Wiggins, P. Eddy

Exhibit #3

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Indian Health Service

Memorandum

Date JUL 10 1989

From Director

SGM-89-2

Subject Special General Memorandum

To All Area Directors

The Indian Health Service (IHS) is implementing an operating procedure for the review and processing of travel vouchers for selected IHS personnel. Effective July 1, 1989, and pertaining to all travel performed on or after that date and until further notice, IHS will require a central office review of travel vouchers for key staff of each Area Office.

To comply with the recommendations of the Office of the Inspector General of the Department of Health and Human Services, a central office pre payment audit of all travel vouchers for each Area Director will be required. In addition, a post payment audit will be performed for travel vouchers submitted by the Deputy Area Director, the Area Executive Officer, and the Area Chief Medical Officer.

Instructions

Area Directors

To obtain reimbursement for official travel, after completion of a trip the Area Director must submit his/her complete original travel voucher together with all necessary documentation to the Division of Resources Management in Rockville, Maryland, addressed to the attention of Ione Parkinson. The voucher will be verified against the travel plan for that Director, which was previously approved by the Director, IHS. If the trip is on the plan, and all documentation is attached to support the claim, the voucher will be forwarded to the Division of Fiscal Services, Travel Section (DFS/TS), Health Resources and Services Administration for processing. If the trip is not part of an approved plan, Ms. Parkinson will forward it to the Director, IHS for review prior to referral to DFS/TS. If the trip is not approved, the voucher will be returned to the Area Office for collection of monies owed. The DFS/TS will audit the vouchers for approved trips and issue a check for monies owed to the traveler within 72 hours of receipt. If for any reason the DFS/TS disallows any portion of the claim, an explanation will accompany the check with the name of the individual to contact if there is a question. On a monthly basis, the DFS/TS will bill each Area Office for all payments issued.

Area Directors' Staff

On a monthly basis, the Financial Management Officers for each Area Office will batch all paid vouchers for key personnel indicated above and forward them to the attention of Ione Parkinson in the IHS, Division of Resources Management, with all supporting documentation. These will be logged and forwarded to the DFS/TS for a post payment audit. If this audit results in a claim disallowance, the respective Area Financial Management Officer will be notified and will take the necessary action to collect the disputed claim.

The vouchers for both the Area Director and the Area Director's staff should be sent as follows:

Indian Health Service
Division of Resources Management, 5A-38
5600 Fishers Lane
Rockville, Maryland 20857
Attention: Ione Parkinson

If you have any questions concerning this issuance you should contact Mr. James Dunnick, Director, Division of Resources Management, Rockville.

Everett R. Rhoades, M.D.
Assistant Surgeon General

Exhibit #4

SUNRISE SPRING:

A TRAINING PROGRAM FOR INDIAN HEA

HEALTH PROMOTION/DISEASI

INTRODUCTION

Perhaps the most characteristic attribute of the Indian Health Service (IHS) from its inception has been its focus on health promotion and disease prevention. The high degree of success of programs such as the provision of safe water and sewage disposal, maintenance of a high rate of immunization, the prophylactic use of isoniazid for tuberculosis, and many other health promotion activities, attest to the importance of this emphasis on health promotion and disease prevention. Largely as a result of the success of these earlier programs, the nature of mortality and morbidity of American Indians has changed. The leading causes of Indian deaths now are heart disease, injuries, cancer, cerebrovascular diseases, and chronic liver disease and cirrhosis. It is universally recognized, in both Indian and non-Indian populations, that the solution to these lifestyle diseases is beyond the scope of the "traditional" medical model with its emphasis on therapy but, rather, dependent upon modification of life style so that these conditions are, in fact, prevented.

It isn't only pathology, however, which dictates that health promotion become the first priority for Indians. An equally compelling reason to promote health and wellness is the continuing need to ration health care. Continued increases in demand for IHS care, ever-increasing health care costs, and undesirability of limiting care to a core set of services have all converged in recent years to create a major crisis in provision of health care to Americans, especially to American Indian and Alaska Natives. As a result, the only practical and available remedy is to decrease the "load" imposed upon a community by keeping people well.

The means by which the IHS promotes wellness is based upon sound epidemiologic principles including: analysis of demographic factors such as age of the population, conditions which result in excess mortality, and is directed toward empowerment of individuals in a community to take charge of, and responsibility for, their own health. The "importation" of services by the federal government, or any other agency, simply will not suffice.

Analysis of the underlying factors in Indian communities indicates that primary attention must be given to the young, and to destructive behavior such as alcohol and substance abuse, and injuries (1). This "modern" approach to health promotion poses an unusual challenge for the traditionally trained health care provider and represents, in fact, a new medical specialty requiring education and training in the concepts and implementation of health promotion activities, especially on a community basis. Further, a new and entirely different relationship between the health care provider and the "patient" must be developed. The fundamental principle in the IHS program is that the health care provider set an example, and lead, the community into wellness. The old practice of a physician advising a patient to stop smoking while he himself is puffing on a cigarette is not acceptable.

Finally, modern medicine, especially community medicine, requires the development of a cohesive and functional team made up of all sorts of health care providers. In the case of health promotion, therefore, not

only must new approaches and techniques be learned, but teams must be developed which can multiply the effects of various individuals each with a special set of skills.

Thus, the IHS has quite appropriately chosen to lead the Indian communities into this new era of community health promotion. Before IHS leaders can make any impact upon a given population, they must first insure that they themselves are following appropriate personal health promotion activities. Changes in Indian communities will likewise depend upon the active involvement of elected leaders in pursuing healthy lifestyles.

Achieving success is difficult and there are relatively few ways in which these various objective may be achieved. An example of one technique which has been successfully employed is that developed by the Albuquerque Area Director, called the Sunrise Springs Retreat, after the rural location chosen because it was considered especially appropriate for Indian people.

DESCRIPTION OF PROGRAM

The Albuquerque Area, like all those of the IHS, possesses certain unique attributes which govern the types of programs located there. This Area is in one of the leading centers of Indian population, containing more than forty tribes each of which is very traditional in outlook and culture, yet

exhibiting the great diversity that is another characteristic of Indian tribes. The Pueblo culture, one of the most traditional in the United States is represented by 38 separate governments, operated by a tribal council and a governor, or cacique, usually selected each year, for a one year term. Refusal to serve as governor carries severe penalties. On the other hand, the Jicarilla and Mescalero Apaches have an altogether different heritage, culture, and governance. (give brief description, include the southern Utes)

A breakthrough of sorts in this Area, in which the tribes have been strongly patriarchical, rather than matriarchical in governance, was the appointment of the first woman Area Director for this Area, Josephine Waconda. Ms. Waconda is a nurse with a distinguished background in public health nursing and health promotion. It is significant that she lives on one of the major reservations in the Area, at Ysleta, where her family is one of the more prominent.

The Albuquerque Area has played a leading role in a the development and implementation of health promotion activities. These have included one of the more innovative programs designed for adolescents, a teen clinic, utilizing teen-aged individuals as peer counselors for other Indian youth. Perhaps more widely known is the pioneering work of Leonard and Wilson in the fitness program at Zuni Pueblo. (ref).

It is not surprising that the new Area Director chose to build further upon this already solid base of health promotion. As the first woman director of the Albuquerque, it was important for her to demonstrate her leadership not only to the tribes but also to the IHS personnel. More recently, the Area has been deeply engaged in the promotion of alcohol prevention with an emphasis on youth. The adolescent treatment and prevention center established at Acoma-Canoncito-Laguna (ACL) was one of the very first in the nation.

The new Area director was thus faced with the need to develop her own team; have this team become a cohesive unit, direct the energy and attention of the health team more toward health promotion, but with a special emphasis on the prevention of alcoholism. Her goal was "to get the various levels and disciplines of the Area personnel to see each other as individuals and persons, not just professional people holding certain jobs" (personal communication).

The "Sunrise Springs Health Care Programs and Fitness Connection[?]" training for leaders in the Indian Health Service (IHS) and the tribal community was a structured training activity with both didactic and practicum components. The location at the Sunrise Springs Resort, LaCienega, New Mexico, was chosen because of its rural setting essential to Indian values, and its facilities for education and fitness training. The training was conducted as a retreat; that is, a period of training away from the intrusion of daily activities. The facilities included a

wellness center that provided appropriate nutritious meals, walking and jogging paths, and a number of health-related activities and programs.

The specific objectives of the program were to assist participants to: (1) set personal health management goals; (2) translate these goals to work productivity improvement; and (3) enhance their ability to work toward the 1990 PHS objectives for the nation which focus on Preventive Services, Health Protection and Health Promotion (ref); test whether such an activity would result in positive lifestyle change; and (4) increase their ability to influence community health promotion. All activities were focused on building knowledge and skills around wellness, developing team building skills and strategies, and improving community capabilities to initiate and sustain health promotion activities.

The Program emphasized nutrition, exercise, reduction of stress, understanding the health potential of one's body, the negative effects of no exercise, each participant's commitment to the program and enthusiasm about incorporating wellness concepts into their own lifestyle, promoting a positive attitude about life, developing a desire for quality work and quality health care, and instructing each participant on follow-up procedures to implement at work and in their community. Many of the IHS employees, such as the Area Director herself, live on the reservations and were expected to set the proper example there. The majority of the 35 participants were Indian. Invitations were extended to all Area tribal leaders, with two tribal leaders accepting the invitation.

The faculty consisted of individuals well known in the fields of alcoholism treatment and prevention, nutrition, health, and fitness and included:

Daniel J. Anderson, Ph.D., President Emeritus, Hazelden Foundation an internationally known Alcoholi.. Training & Treatment Center

Milton Garret, Ph.D., Professor, Department of Curriculum and Instruction, University of New Mexico

Tom McLean, M.D., Executive Director, University of New Mexico Wellness Center and authority on wellness, fitness, and exercise physiology

Bruce Leonard, public health educator, fitness expert, nationally recognized for his pioneering work in community wellness at Zuni Reservation

Mary A. Benton, an internationally recognized fitness consultant

Jeff Galloway, a nationally known runner, fitness expert, and author of Galloway's Book on Running

Barbara Galloway, a Women's Fitness Consultant

Judy Taylor, M.S., Lifestyle Counselor, author of Bridling Your Body a lifestyle program that emphasizes nutrition, exercise and lifestyle changes

Kathleen Westcott, art therapist, specializing in art therapy for chemically dependent adolescents

The Sunrise Springs experience consisted of five days of intensive training, including workshops and seminars on the cardiovascular benefits

of exercise, nutrition, stress management, substance abuse strategies, team building, and community health promotion strategies.

A typical day at Sunrise Springs began with a one-hour walk at 7:00 a.m.. The walk provided support in getting exercise on a daily basis as the first step in a series of programs and events which promote the concept of wellness

The first meal of the day at 8:30 a.m. marked a basic change in the group's eating habits. The participants were served only nutritious meals and learned that healthy food can taste good.

Following breakfast, each participant received individualized health consultations, providing the attendees the opportunity to discuss health problems, such as how to reduce and control stress through healthy lifestyles. There was a continuous effort to provide support to the participants, both individually and collectively. The participants discussed how they could become "role models" when they returned to their communities.

From 10:00 a.m. to Noon, the group assembled for didactic sessions such as that provided by Dr. Anderson who talked about "Stress Management Without Substance Abuse," in which the group learned about lifestyles free of chemical dependency and addictions. Dr. Anderson presented ways to reduce and control stress and increase productivity.

A one-half hour break was provided before the group met for lunch from 12:30 p.m. to 1:30 p.m. At the luncheon, the attendees discussed the fact that "lighter" food actually does taste good. Recipes for the day's meal were given to each participant. After lunch there was a discussion as to how the daily exercise routine coupled with nutritious yet tasty meals can change lifestyles and habits.

Following lunch, an hour of team building centered around a "fun" activity. Each person participated in an activity that emphasized fun and helped keep them psychologically as well as physically fit.

At 2:30 p.m., participants gathered for another didactic session, such as that provided by Dr. McLean, who talked about "Fitness of the Heart," with review of each participants' individual health plans. Following Dr. McLean's discussion, Ms. Galloway instructed the group on the importance of proper equipment and apparel for exercising. She also demonstrated stretching techniques that are specific to gender and type of exercise.

After the seminar, a walking break from 4:30 p.m. to 6:30 p.m. brought everyone together to discuss the day's events, especially the individual and group efforts to change lifestyles. The walk also brought out a discussion of how their lifestyle changes could help them become role models for their communities.

The day closed with an informal discussion at 8:00 p.m. in the evening around an outdoor campfire. This provided the participants with the opportunitv

to evaluate their own and other's progress and encourage each other's efforts to become healthy. A distinct group spirit soon surfaced by employing these sessions.

Dr. McLean stressed the benefits of exercise and provided information on the human cardiovascular system. Dr. Garrett's lecture, "Getting More Results With Less Effort" dealt with important management issues such as empowering people in a health organization climate. Mr. Galloway's seminars and demonstrations on exercises motivated and prepared participants for setting goals for wellness. Some examples of Mr. Galloway's topics were, "The Problems With Exercises," participation in physical and psychological training demonstrations; "Exercise Without Pain," injury prevention and motivational techniques; and "Mind Power" mental conditioning as a result of a cardiovascular exercise program. Ms. Galloway instructed participants on the importance and features of proper equipment and apparel while exercising. The Galloways jointly presented, "Health Net New Mexico," a briefing and update on Community Health promotion activities in the State of New Mexico, with emphasis on strategies developed in Indian communities through cooperation with the Indian Health Service. Other sessions on nutrition and wellness behavior stimulated many ideas which participants used when they returned to their own communities and work sites.

Physiological assessments conducted by the Wellness Center of the University of New Mexico were completed on each participant prior to the course. Follow-up evaluation included interviews with participants from

three Service Units and the Area Office. The results of the evaluation indicated the seminar was an important milestone in the development of health promotion programming, and in meeting IHS and PHS health care objectives. It represented a pioneering demonstration that such an effort should lead to efforts in various communities with a high expectation of success.

Techniques for stress control included massage therapy, alpha chamber meditation, and acupuncture. The alpha chamber is a sensory deprivation apparatus which facilitates meditation, an important Indian procedure which has fallen into disuse. Fourteen individuals went through this exercise. The name of the chamber refers to the alpha state of mentation which may be achieved through meditation and which has been shown to reduce stress (ref). One participant used acupuncture to relieve chronic pain in his knee which was the result of a high school football injury.

DISCUSSION

Two examples of individual and community change after the Sunrise Springs training activity will illustrate its success. One of the IHS Service Unit Directors, an enrolled tribal member, was originally skeptical about the value of the program and did not wish to attend the training session. The combination of education content, the team building with a group of peers, the emphasis on the outdoors and Indian values, the motivational

activities to take charge of one's own health, resulted in this individual's commitment to fundamentally change his style of life. As a result, he subsequently instituted a personal exercise program for his own staff, lost approximately 15 pounds of weight, became a certified aerobics instructor, and now leads an after-work exercise program for employees.

A second example of the success of the Sunrise Springs program involved a tribal leader achieving a commitment to wellness from an entire community. A short time after his participation, one of the tribal leaders announced in an general meeting, his tribe's commitment to become the first in the Albuquerque Area to achieve an alcohol-free community.

The implications of the Sunrise Springs experience for alcoholism prevention did not arise accidentally. A major underlying premise of the Sunrise Springs activity was that the promotion of wellness is perhaps the most important current approach to the problem of alcoholism. The IHS has been actively supporting school and community based prevention activities for ten years. With the passage in 1986 of P.L. 99-570 and explicit authorization for health promotion activities in that law, the IHS expanded its efforts even further. The scourge of alcoholism will not be controlled until the individual and the community understand the health consequences of alcohol abuse, what can be done to deal effectively with it, and become committed to implementing the necessary changes in their individual and community life. The Greek ideal of a sound mind in a sound body is also the traditional Indian ideal, an ideal which must be regained. This theme ran throughout the program.

Peter M. Sandman, Ph.D., in a speech at the Rutgers University forum on biotechnology and ethics described the dichotomy between risk identification and the estimation of the hazard, which are the province of the experts, and "outrage" or the public's perception of the hazard. Real progress in dealing with a problem takes place when "outrage" is focused on a true hazard. The goal should be to use society's limited "time, energy, attention, and money" on the most serious hazards. As Dr. Sandman states "Real people die . . . because we are more attentive to outrage than to hazard." He goes on to recommend that:

> "[W]e need to teach people about hazard, to help them understand what the serious risks are from a health perspective. That is the long term answer. . . .[W]e need to do everything we can to make serious hazards outrageous. . . .[W]e have to stop exacerbating the outrage of insignificant hazards. . . .When people are treated with fairness and honesty and respect for their right to make their own decisions, they are a lot more likely to focus their concerns and actions on the hazards that really count." (Sandman, Peter M., Ph.D., Risky Business; Rutgers Magazine, April - June 1989. pp. 36-37)

REFERENCES

1. Rhoades, E.R., Hammond, J., Welty, T.K., Handler, A.O., and Amler, R.W. The Indian Burden of Illness and Future Interventions. Public Health Rep. 102: 361-368, 1987.

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A Minimum of 12 Percent of IHS Resources were Spent on Services Related to Alcoholism in FY 1988

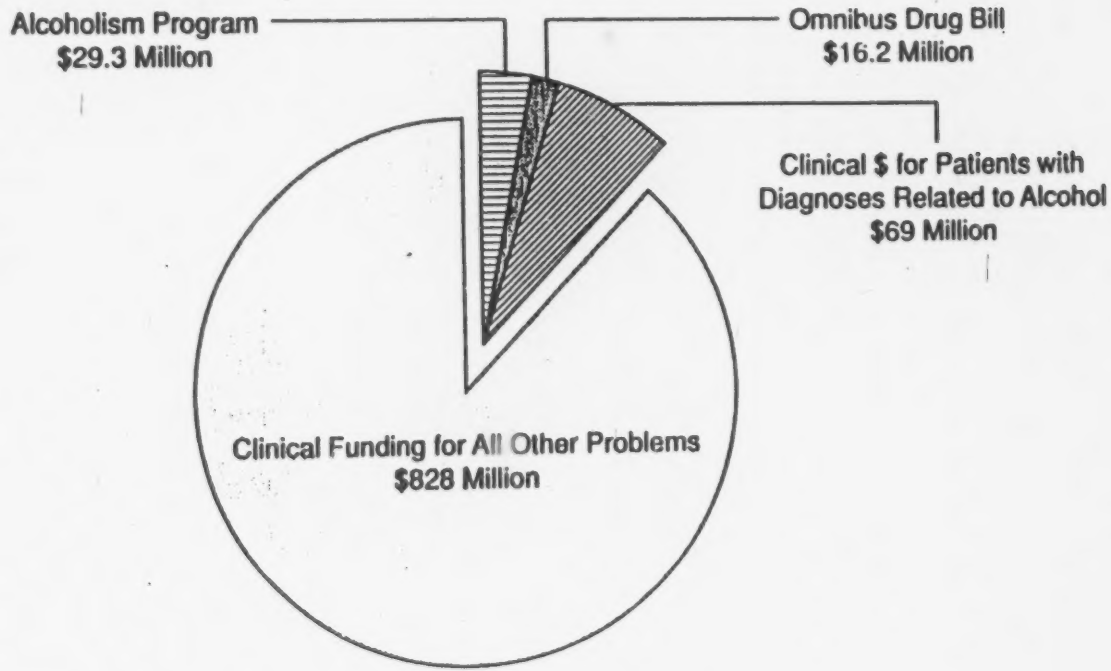


Exhibit #5

Alcoholism Funding

Charts: A Minimum of 12 Percent of IHS Resources were Spent on Services Related Alcoholism in FY 1988

Claim: IHS spends only 3 percent of its resources on Alcohol problems.

Source: FY 1988 budget for Alcohol line item.
FY 1988 budget for Omnibus Drug Bill funding in H&C

Clinical funding for patients was estimated by applying workload ratios to the H&C and CHS budgets for FY 1988. The ratios were developed using a combination of inpatient and ambulatory workloads. An ORD survey of inpatient facilities for counts of patients with alcohol related dianoses and a tabulation of outpatient diagnoses for 1988 was used to develop the ratios.

Analysis:

- Approximately $115 million (12%) was spent on alcohol programs and services to patients with diagnoses related to alcohol abuse.
- The estimate of clinical services funding spent on alcohol is probably conservative, since many medical problems are an indirect result of alcohol and drug abuse.

Conclusion: IHS is spending considerably more than 3 percent of its budget on problems of alcoholism.

Exhibit #6

HEALTH STATUS
CHARTS AND NARRATIVE
IN RESPONSE TO OFFICE OF TECHNOLOGY ASSESSMENT

TESTIMONY BEFORE THE
SENATE SPECIAL COMMITTEE ON INVESTIGATIONS

MAY 24, 1989

Tony D'Angelo
Craig Vanderwagen
Cliff Wiggins

IHS SERVICE AREA VERSUS RESERVATION STATES

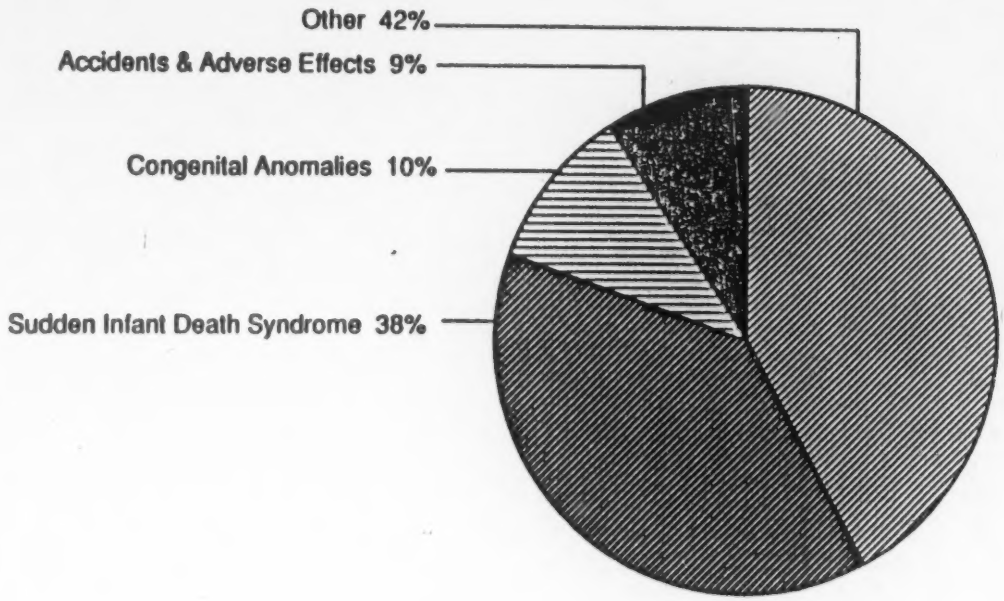
ALLEGATION: IHS is attempting to portray Indian health status as better than it really is by showing reservation state rather than IHS service area mortality rates in the IHS Chart Series Book.

RESPONSE: IHS publishes mortality rates for the reservation states in the IHS Chart Series Book in order to show trends going back to 1955. IHS service area data are not available prior to 1972. This is clearly stated in the Chart Series Book. A chief function of the Chart Series Book is to depict these trends, showing both improvements and increasing problems. The trends are essentially the same regardless of which geographic area is used.

IHS publishes both reservation state data and IHS service area data depending upon the purposes of the report, and the availability of the data. In addition, IHS has always made its data bases available to outside users.

In fact, IHS worked with the Office of Technology Assessment (OTA) in the preparation of their study, "Indian Health Care." IHS provided OTA with the Indian mortality data files, advised OTA on how to analyze the data, and reviewed the results of OTA analyses. IHS advised OTA that for the purposes of their study, IHS service area rather than reservation state mortality rates would be more appropriate.

CAUSES OF INDIAN POSTNEONATAL DEATHS
IHS SERVICE AREA, 1984-86



Postneonatal Deaths

CHART: Causes of Indian Postneonatal Deaths
IHS Service Area, 1984-86

PROBLEM: Indians have a considerably higher postneonatal death rate than their counterparts in the general population.

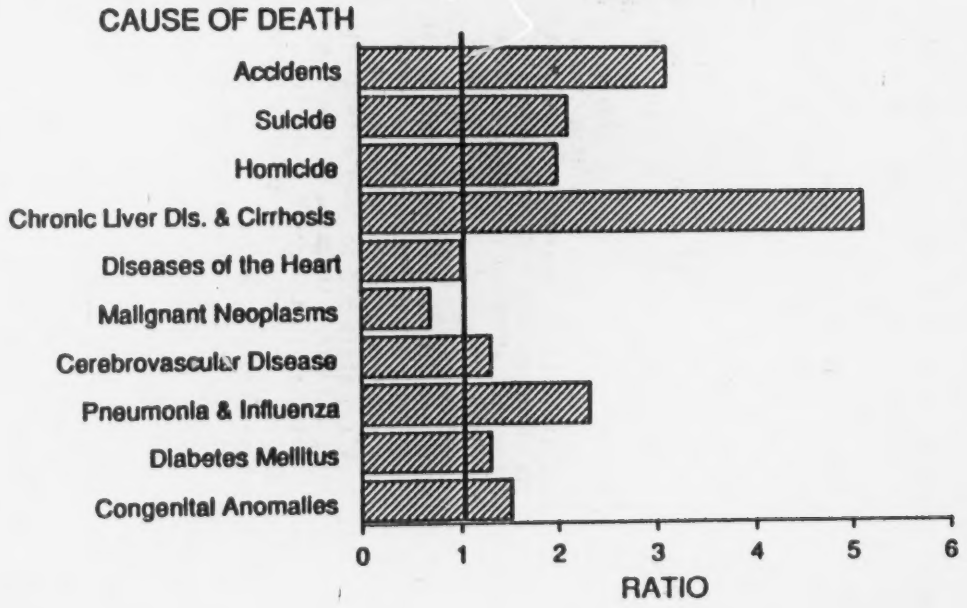
SOURCES OF DATA: IHS Vital Events Computer System.
National Center for Health Statistics

ANALYSIS OF DATA: The Indian neonatal mortality rate is less than the rate for the general population, while the Indian postneonatal rate is greater. However, more than 57 percent of Indian postneonatal deaths are attributed to causes which the medical system has no proven effective intervention, i.e., sudden infant death syndrome, congenital anomalies, and accidents and adverse effects.

IHS INITIATIVES: IHS is aggressively investigating the causal factors involved in these deaths. In the case of SIDS, the IHS has, with the American Academy of Pediatrics, been researching the circumstances and epidemiologic factors associated with SIDS in American Indian and Alaska Native populations. It is hoped that this research will reveal opportunities for identification of high risk factors and prevention. The IHS injury control program is making significant inroads into the analysis of factors contributing to injuries and strategies for prevention.

TEN LEADING CAUSES OF DEATH FOR INDIANS 15-44 YEARS OF AGE AND RATIO OF MORTALITY RATES

IHS SERVICE AREA (1984-86) TO U.S. ALL RACES (1985)



Deaths for Indians 15-44 Years Old

CHART: Ten Leading Causes of Death for Indians 15-44 Years of Age and Ratio of Mortality Rates IHS Service Area (1984-86) to U.S. All Races (1985)

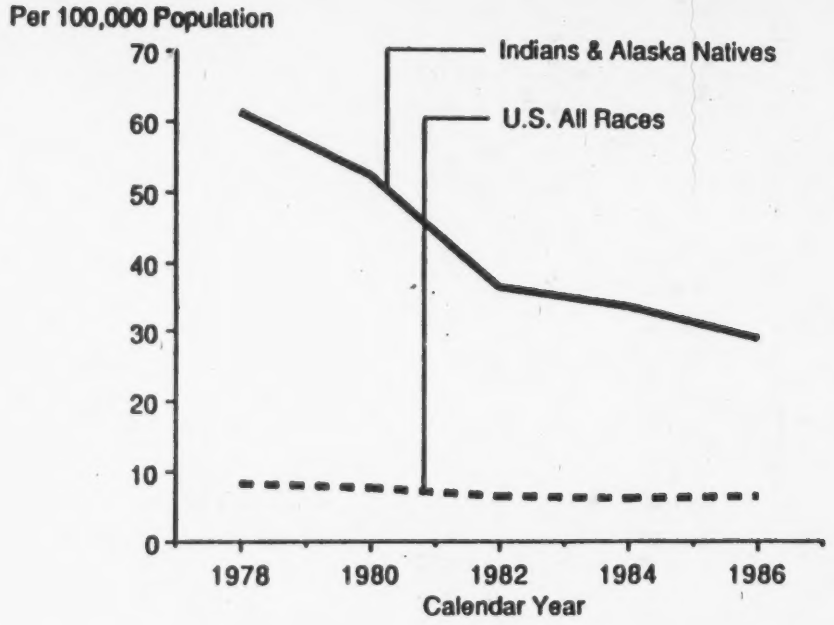
PROBLEM: Indians, 15 to 44 years of age, have considerably higher death rates than their counterparts in the general population.

SOURCES OF DATA: IHS Vital Events Computer System.
National Center for Health Statistics.

ANALYSIS OF DATA: The top four causes of death for this age group (i.e., accidents, suicide, homicide, chronic liver disease and cirrhosis) are greatly influenced by social or external factors that are largely beyond the control of the health care system. These four causes comprise 70 percent of all deaths for this age group, and the ratios of their mortality rates to those of the general population range from 2.0 to 5.1. In contrast, the 5th and 6th leading causes of death for Indians in this age group, diseases of the heart and malignant neoplasms, have lower mortality rates compared to the general population. These are health problems that are more amenable to medical treatment.

IHS INITIATIVES: Notwithstanding these facts, the IHS has initiated a vigorous program of health promotion and disease prevention specifically targeted to this age group. This has included: a broad assessment of health behaviors and attitudes to more effectively target program activity; clinical services targeted at teens, with a prevention focus; community-wide initiatives to provide more structured and productive recreational outlets for youth; and the initiation of a variety of school and community-based educational interventions. These efforts are having a positive effect in the declines demonstrated in alcohol and accident related mortality.

AGE ADJUSTED ALCOHOLISM DEATH RATES



Alcoholism Deaths

CHART: Age-adjusted Alcoholism Death Rates

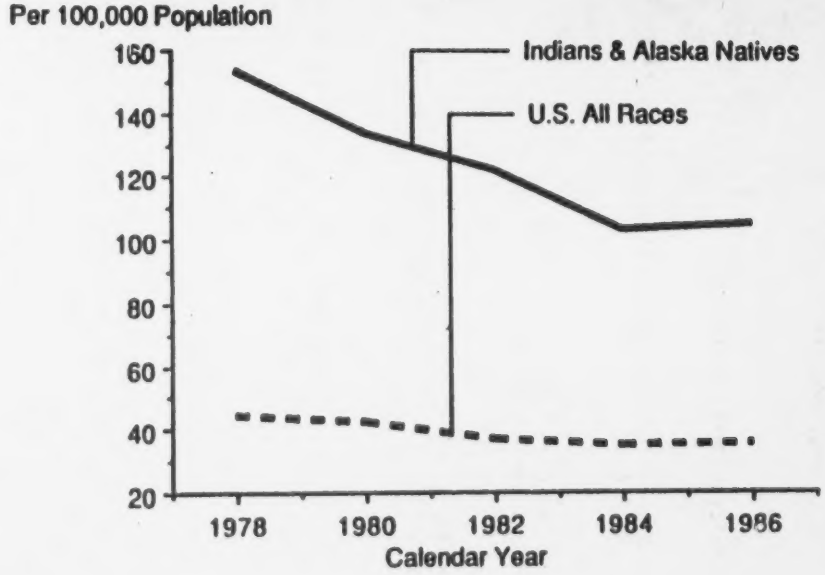
PROBLEM: Indians have a considerably higher age-adjusted alcoholism death rate than the general population.

SOURCES OF DATA: IHS Vital Events Computer System.
National Center for Health Statistics.

ANALYSIS OF DATA: The age-adjusted alcoholism death rate for Indians decreased 52 percent between 1978 and 1986, while the rate for the general population decreased 21 percent.

IHS INITIATIVES: This is a significant difference and is in part attributable to more effective medical management and prevention interventions. The IHS sponsors over 400 different prevention activities through its alcohol and substance abuse program. These prevention interventions include: primary prevention through education (babes, project charlie, etc) in schools, community educational activities, fitness activities, and other self-image enhancing events.

AGE ADJUSTED ACCIDENT DEATH RATES



Accident Deaths

CHART: Age-adjusted Accident Death Rates

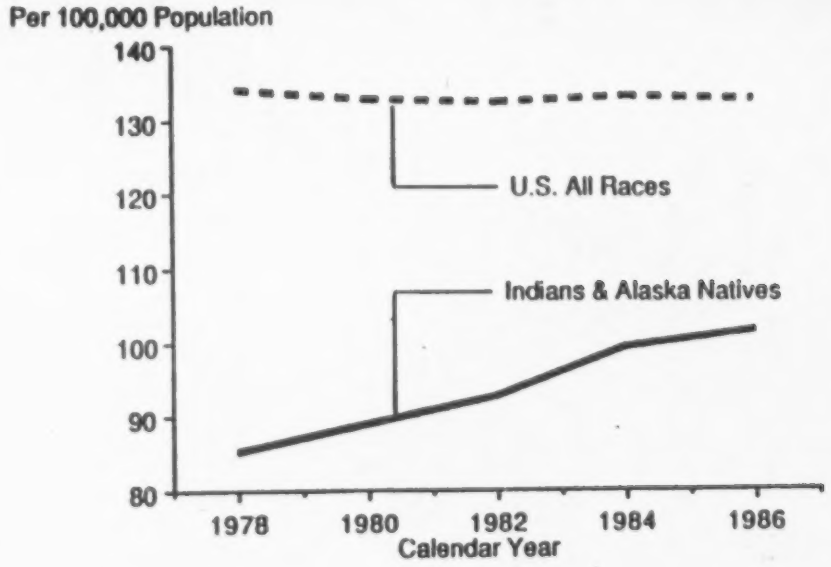
PROBLEM: Indians have a considerably higher age-adjusted accident death rate than the general population.

SOURCES OF DATA: IHS Vital Events Computer System.
National Center for Health Statistics.

ANALYSIS OF DATA: The age-adjusted accident death rate for Indians decreased 31 percent between 1978 and 1986, while the rate for the general population decreased 21 percent.

IHS INITIATIVES: The IHS has a unique program of injury prevention that includes: a national poster competition, an injury control fellowship program, an infant restraint program, and a variety of other innovations.

AGE ADJUSTED MALIGNANT NEOPLASM DEATH RATES



Malignant Neoplasm Deaths

CHART: Age-adjusted Malignant Neoplasm Death Rates

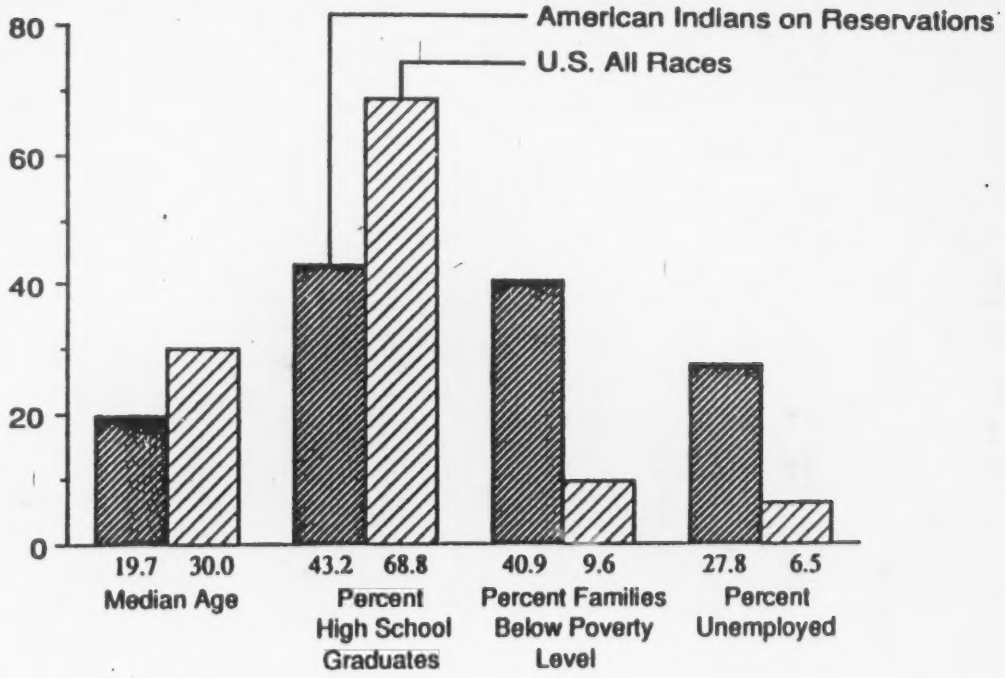
PROBLEM: Indians have a lower age-adjusted malignant neoplasm death rate than the general population, but the gap is narrowing.

SOURCES OF DATA: IHS Vital Events Computer System.
National Center for Health Statistics.

ANALYSIS OF DATA: The age-adjusted malignant neoplasm death rate for Indians increased 19 percent between 1978 and 1986, while the rate for the general population essentially remained the same.

IHS INITIATIVES: This rise is in part attributable to the increasing longevity of American Indian and Alaska Native people. That is, a positive outcome of IHS activity has been an increase in the number of American Indians and Alaska Natives living long enough to reach the age where neoplastic disease occurs most frequently. However, it offers new challenges in prevention of disease to maintain the American Indian and Alaska Native mortality rates below that of the U.S. population. The IHS has begun a series of indepth cancer epidemiologic studies, tumor registry activities, and outreach and prevention initiatives both alone and in collaboration with the National Cancer Institute.

SOCIAL AND ECONOMIC CHARACTERISTICS
1980 CENSUS AND INDIAN SUPPLEMENTARY QUESTIONNAIRE



Social and Economic Characteristics

CHART: Social and Economic Characteristics

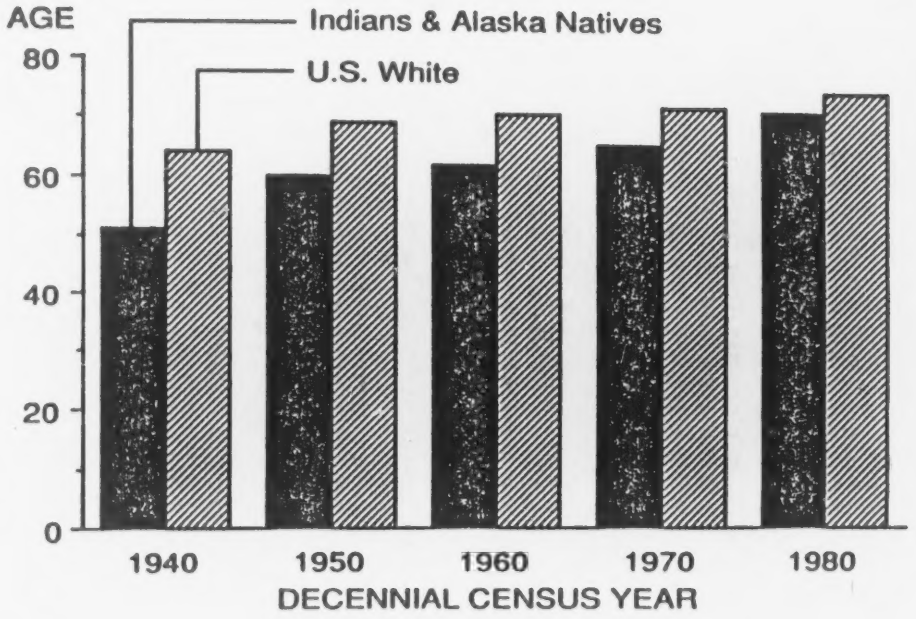
PROBLEM: The Indian population lags behind the general population with respect to various income, education, and employment characteristics.

SOURCES OF DATA: 1980 Census.
1980 Census Supplementary Questionnarie for American Indians.

ANALYSIS OF DATA: According to the 1980 Census and Indian Supplementary Questionnaire, Indians on reservations are younger than the general population (median age: 19.7 to 30.0), less educated (percent high school graduates: 43.2 to 68.8), poorer (percent families below poverty level: 40.9 to 9.6), and less employed (percent unemployed: 27.8 to 6.5).

IHS INITIATIVES: These factors all contributed to a higher incidence of certain diseases. These diseases are preventable and that is the challenge that confronts IHS today. It is a challenge which IHS is vigorously addressing through its prevention and health promotion activities in alcohol, mental health and other service activities.

Life Expectancy at Birth



Life Expectancy

CHART: Life Expectancy at Birth

PROBLEM: Indians die at younger ages than the general population.

SOURCES OF DATA: IHS Vital Events Computer System.
National Center for Health Statistics.

ANALYSIS OF DATA: Life expectancy at birth for Indians has increased from 51.0 years in 1939-41 to 71.1 years in 1979-81. However, it is still 3.3 years less than the 1980 figure of 74.4 years for the U.S. White population.

IHS INITIATIVES: The general health of American Indians and Alaska Natives has improved greatly. Some IHS initiatives which have contributed to this change include: water and sanitation facilities, maternal and child health services (including immunizations, obstetrical and well-child services), improved nutritional awareness, and a variety of other prevention and clinical interventions.

Exhibit #7

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20857

MAY 23 1989

NOTE TO THE DIRECTOR

Dr. Nicholson, Aberdeen Area, testified at the hearing of the Special Committee on Investigations that there were 26 infant deaths in the Pine Ridge Service Unit during 1987. He stated that there were somewhat over 500 live births, and therefore the infant mortality rate was over 40 per 1,000 live births.

I talked to Dr. Nicholson after the hearing, and asked him whether his infant mortality data came from the South Dakota Vital Events Office. He answered in the negative, stating that these were deaths that the staff was aware of at the Pine Ridge Hospital.

The vital events data base that we have in Headquarters consists of data that comes from the State Vital Events Offices through the National Center for Health Statistics. For this data base, 1986 is the latest year of data available to IHS. The attached table shows the number of infant deaths and infant mortality rate for 1978 through 1986 for residents of the Pine Ridge Service Unit. The annual rates averaged 26 infant deaths per 1,000 live births. In no year was there more than 17 deaths.

State vital event data are subject to two main problems: 1) the Indians in the State data base may not be eligible for IHS services or users of IHS services, and 2) Indian race may be underreported on the certificates. However, these problems are expected to be minimal for the Pine Ridge Service Unit since most Indians there live on reservation land. Therefore, except for any infant deaths occurring in the Pine Ridge Hospital for non-residents of the Pine Ridge Service Unit, we would expect to have more infant deaths recorded in the vital events data base than actually occurred at the facility. The table shows, at least for 1986, that this would not be the case if Dr. Nicholson's figure of 26 infant deaths is correct. However, it is possible but not probable that the number of deaths increased from 17 in 1986 to 26 in 1987.

We also checked our inpatient information system for birth and infant death data for the Pine Ridge Hospital, both direct and contract. This data base showed only 5 infant deaths for 480 births in 1987. The figures for fiscal year 1988 were 3 deaths and 472 births, and for 1986 they were 2 deaths and 435 births. Of course, not all vital events pertaining to Pine Ridge residents would have necessarily occurred in the Pine Ridge Hospital. The Aberdeen Area Planning/Statistics Office informed us that they were not aware of any problem with their inpatient data.

In summary, our data depict an infant mortality problem of a lesser magnitude than that quoted by Dr. Nicholson in his testimony. The infant mortality rate for residents of the Pine Ridge Service Unit is still alarmingly high, i.e., 32.5 per 1,000 live births in 1986, which is 2.9 times that for the IHS service area (11.1).

A. J. D'G

Anthony J. D'Angelo
Director
Division of Program Statistics

INFANT MORTALITY
AMERICAN INDIAN BIRTHS AND INFANT DEATHS, FOR RESIDENTS
OF PINE RIDGE SERVICE UNIT, 1978 - 1986

Calendar Year	Infant Deaths	Births	Rate per 1,000 Live Births
1986	17	523	32.5
1985	16	550	29.1
1984	11	516	21.3
1983	17	504	33.7
1982	16	509	31.4
1981	6	443	13.5
1980	12	479	25.1
1979	13	454	28.6
1978	8	412	19.4

Vital Events Staff
DPS/OPEL/IHS
May 17, 1989
0312r

Redistribution Constraints

- At consultation conferences on RAM, most tribes have said "Go Slow."
- Reports accompanying Appropriations limited reallocation of base funding to 3% (1987) and 5% (1988).
- The Amended 'Self-Determination' Act forbids reductions in funding for '638' contractors.
- The Indian Health Care Amendments of 1989 require a report to Congress before the Agency can reallocate more than 5% of the base.

Exhibit #8

Historical Funding

Chart: Redistribution Redistribution Constraints

Claim: IHS only funds areas on a historical basis. No efforts are made to redistribute base funding.

Source: These bullets represent the messages provided to the IHS from the Indian people through extensive consultation on RAM, from the Congress as reports accompanying appropriations, from the 638 Amendments, and from the 437 Amendments.

Analysis:

- The IHS must go slow in redistribution of existing, already inadequate resources.
- Tribes have argued that it does not make sense to reduce inadequately funded program to transfer funds to other programs.
- The political pressure to protect 'base' funding has been great.
- In 1987, the IHS redistributed 2% of the base funding of Areas using the ARAM. Two years of using monies from mandatories for RAM have not allowed many programs to maintain pace with inflation.
- The 638 language protecting the funding of contractors effectively eliminates redistribution as an option for a substantial portion of the IHS program.
- The 437 language requires a report to Congress before the IHS can reallocate 5% or more of the base funding.

Conclusion: The IHS has been responsive to the message of Indian tribes and the Congress to reallocate base funding only as a last resort.

Exhibit #9

Needs Based Funding (ARAM)

Charts: *(3 Charts are provided on this topic)*

1. The IHS Needs-Based Allocation System
2. $153 Million Was Distributed to IHS Areas During 1981-1989 Using Needs-Based Allocation Formulas
3. Percentage Increase in Clinical Funding by ARAM Allocations 1981-1989

Claim: IHS funding is not responsive to NEEDS in the field.

Source: Formula reflects ARAM components for clinical services. Other needs based formulas were variations on this general theme.

Data are from resource allocation records 1981-1989. "Equity" funding, "pre-RAM" formula of 1984, ARAM funding, and Indirect Cost funding are included.

Cumulative allocations from all formulas are shown for 1981-1989. Percentage increase are shown for ARAM only for 1984-1989.

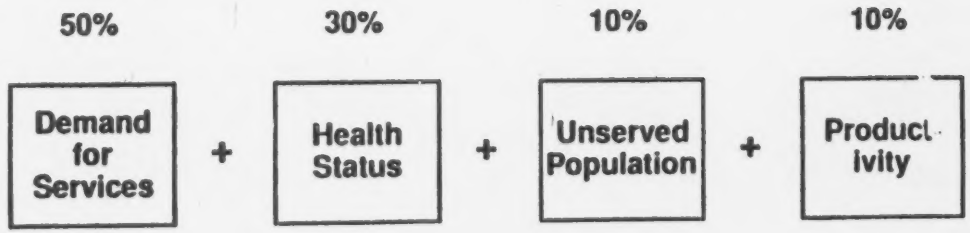
Analysis:

- The formula shows the four constituent needs indices used for ARAM. The percentage weights vary somewhat depending upon type of program.
- Bar charts clearly show the differential allocations to areas that resulted from these needs based formulas.
- California area has received the most funding over the past 9 years considering Equity, ARAM, and IDC formulas.
- The Aberdeen area has benefited from the largest PERCENTAGE increase due to ARAM formulas.
- Note: Inequities still exist. The question becomes one of the velocity of movement towards equity balanced with the need to prevent disruption of existing programs.

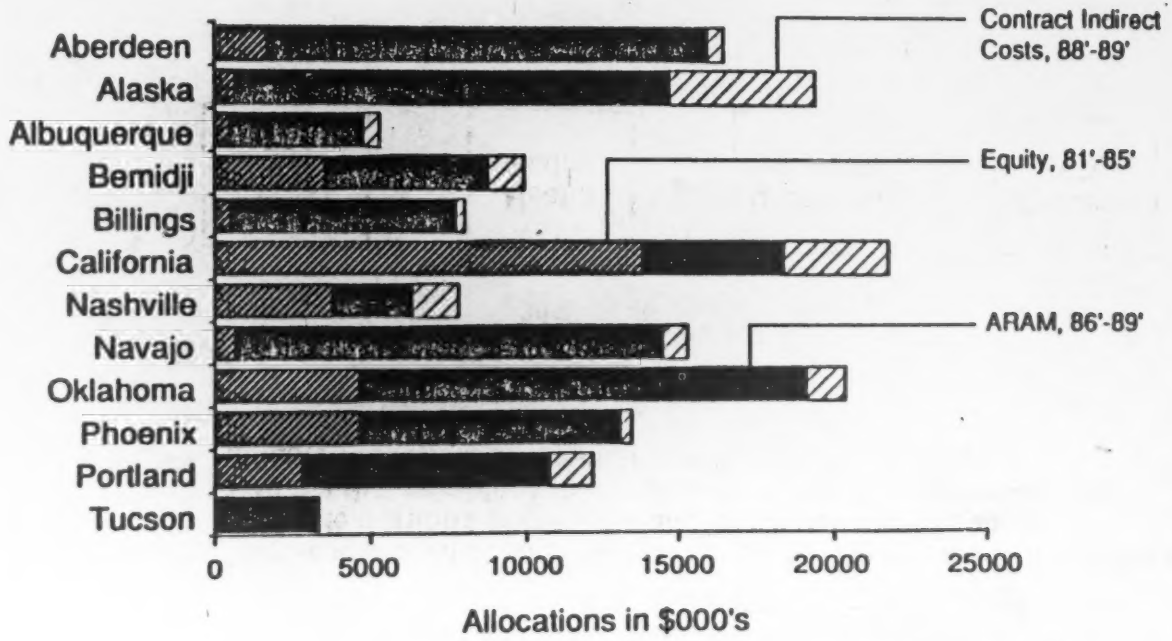
Conclusion: IHS has considered NEED in its funding policy. The cumulative result is more equitable funding through out IHS, although inequities still exist and are continously addressed by the IHS resource allocation policy.

The IHS Needs-Based Allocation System

The Resource Allocation Methodology (ARAM) is used to distribute available portions of the IHS budget to areas based upon a formula that combines four indices of need. All four indices are adjusted to reflect differential medical costs in each area.

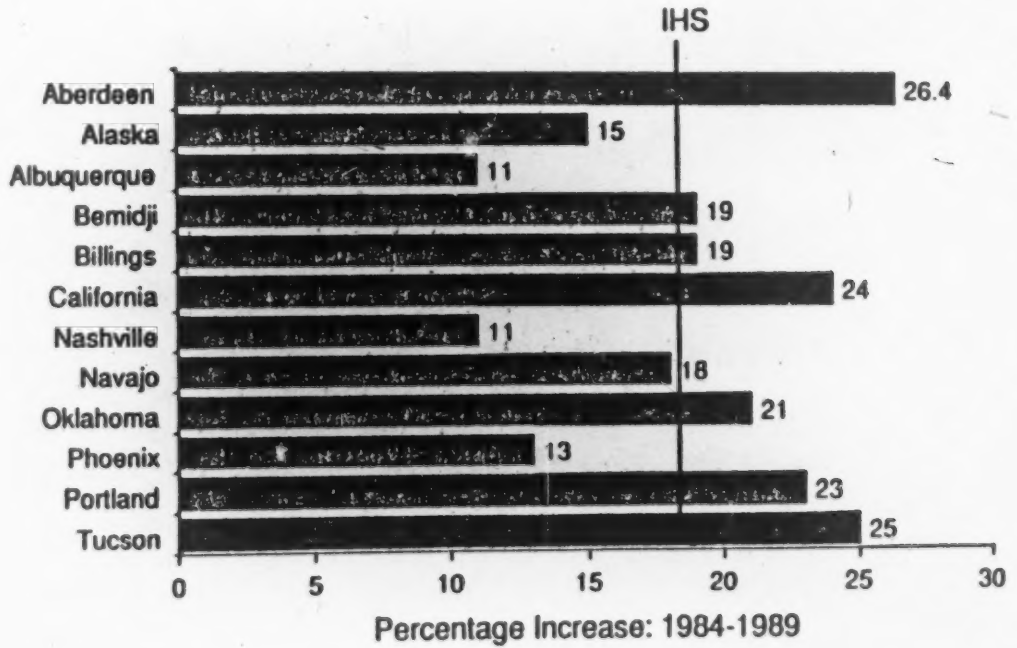


$153 Million Was Distributed to IHS Areas During 1981-1989 Using Needs-Based Allocation Formulas



Funds were allocated in the Hospitals & Clinics, CHS, Dental, and Alcohol categories.
The Equity and ARAM allocations were based upon clinical funding needs of federal and tribal programs.
The Contract Indirect Cost allocations were based upon administrative funding needs of tribal contractors.

Percentage Increase in Clinical Funding by ARAM Allocations 1984 - 1989



Aberdeen Area Questions

Charts: ARAM Funding, Number of MDs, Workload Per MD
Percentage Change in Aberdeen Area and IHS: 1984-1988

Claim: Hasn't the IHS ignored the needs of programs and staffing in the Aberdeen Area?

Source: The funding data are from the ARAM allocation records for 1984 to 1989.

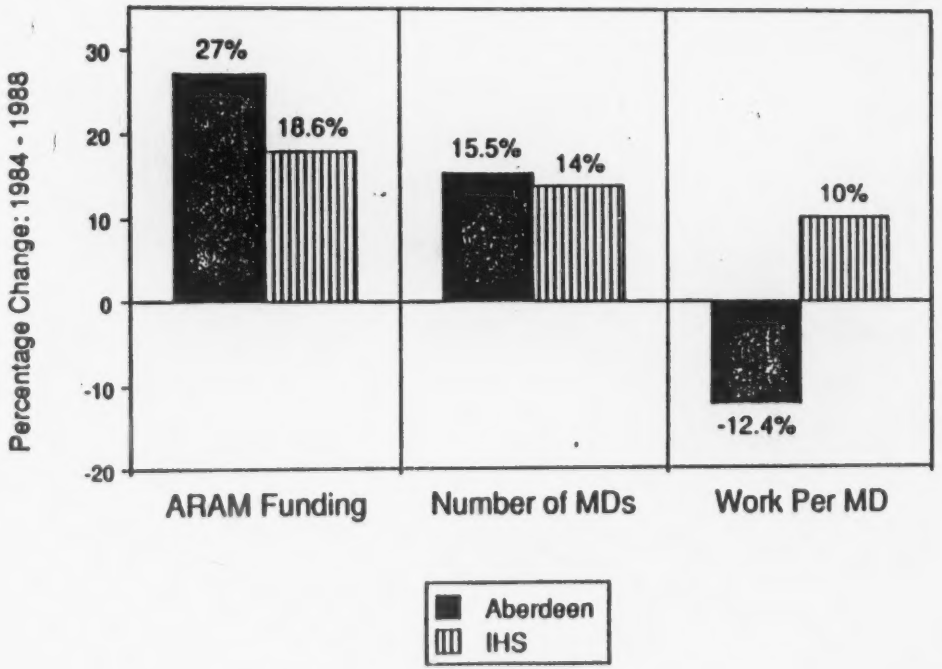
The physician staffing data are from a special report by the Director, Aberdeen Area (1988). The IHS average data actually reflect a combination of data from 5 IHS areas (Albuq., Alaska, Okl., Phoenix, Navajo) that have comparable size and focus upon direct services delivery including hospitals.

Analysis:

- Aberdeen clinical funding has grown 27% since 1984 as a result of ARAM allocations - the highest of any IHS area.
- The number of MDs in Aberdeen has grown by 15.5% - slightly more than the IHS average.
- The workload required per physician has declined 12% in Aberdeen, while during the same period, the workload required per physician for IHS increased by 10%.

Conclusion: The Aberdeen area has received substantial benefits based upon formulas that address needs. The indicators are moving in the right direction in Aberdeen, although we acknowledge that severe problems still remain.

ARAM Funding, Number of MDs, Workload Per MD Percentage Change in Aberdeen Area and IHS: 1984-1988



DEPART[illegible]NT OF HEALTH & HUMAN SERVICES — Office of the Secretary

Washington, D.C. 20201

Exhibit #10

MAY 12 [illegible]

The Honorable Dennis DeConcini
Chairman, Special Committee on Investigations
Select Committee on Indian Affairs
United States Senate
Washington, D.C. 20510

Dear Senator DeConcini:

I wish to apologize for the delay in responding to your March 2 request for certain documents and records relating to financial and contracting activities in the Indian Health Service (IHS), Oklahoma City and Nashville Area Offices. This delay in locating, duplicating, and providing the documents was caused by an unfortunate series of administrative misunderstandings. Let me assure you that IHS staff is working diligently to provide you with the requested material.

I understand that some materials were provided to committee staff visiting the Area Offices. Copies of this material and all other requested materials are scheduled to be submitted to IHS Headquarters no later than May 28 and will be forwarded to you as soon thereafter as possible. Any materials available earlier will be sent to you as received. Your staff has been very helpful in clarifying the scope of the request to enable IHS to respond.

The IHS assures me that the necessary steps are being taken to preserve all records which may fall within the scope of your request.

A similar letter is being sent to Senator John McCain.

Sincerely,

Eleanor Kerr
Deputy Assistant Secretary
for Legislation (Health)

DEPARTMENT OF HEALTH & HUMAN SERVICES — Indian Health Service

Memorandum

Exhibit #11

Date MAY 17 1989

From Director

Subject Information/Data for Senate Investigations

To Area Directors
Associate Directors

We have experienced difficulties in providing information and materials requested by the Special Committee on Investigations of the U.S. Senate Select Committee on Indian Affairs.

In order to ensure responsiveness to the requests of the Special Committee on Investigations, I am designating Mr. Robert A. Marsland, Director of Headquarters Operations, as the key Headquarters contact point. All communications for and through the Area and Associate Directors shall be directed to Mr. Marsland or his designee.

I realize that providing the requested information and materials takes time away from your principal duties and responsibilities, but your efforts will reflect well on the Indian Health Service.

Thank you for your continued cooperation and support in this critically important matter.

Everett R. Rhoades, M.D.
Assistant Surgeon General

Exhibit #12

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Indian Health Service

Memorandum

Date · JUN 30 1989

From Director of Headquarters Operations

SPECIAL

Subject See Attached Request from the Senate Investigating Committee

To Mr. Murray, Director, Division of Personnel Management
Ms. Johnson, Acting Director, Division of Management Policy
Mr. Shoe, Acting Director, Division of Contracts and Grants Policy
Mr. Dunnick, Director, Division of Resource Management

The timeliness, completeness, and quality of the IHS response to the Special Committee on Investigations' request for additional information is critical for maintaining credibility with the Committee, the Department, and PHS.

Because of its nature and urgency, I am managing all assignments and completion of this effort from my office.

Assignments for gathering and indexing the requested documents are as follows:

Item 1. A. Mr. Jim Murray, Director, Division of Personnel Management - All personnel related documents identified in Item 1. We are defining acting as requiring a personnel action whether Civil Service or Commissioned Corps, 30 days or longer.

Jean Davis

B. ~~Ms. Doris Johnson~~, Acting Director, Division of Management Policy - Functional statements, organizational/flow charts, policy and procedure guidelines relating to IHS; and any and all studies of administrative management and organizational issues conducted in the past five years relating to IHS.

Item 2. Mr. Shoe, Acting Director, Division of Contracts and Grants Policy.

Item 3. Mr. Shoe, Acting Director, Division of Contracts and Grants Policy.

Item 4. Mr. Dunnick, Director, Division of Resource Management - Begin with collection of all records back to FY 1986 for:

A. All national or regional conferences or meetings called by the Director and sponsored by IHS principally for policy formulation, program oversight, or program planning that required participation by the Director, Deputy Directors, or CAADs for a period of three working days or more. For these meetings, all participants who attended must be included in the submission of required data.

B. All HP/DP Conferences of $50,000 or more paid for by IHS.

C. Determine what additional records are available from the various records centers that will satisfy the Committee's request for records back to January 1, 1982 and how quickly can we respond to this request? Also, please provide an estimate of the cost.

Mr. McSwain is assigned responsibility for indexing, packaging, and response to the Committee.

Mr. Deffenbaugh is responsible for tracking assignments, providing overall editorial control, and managing clearance of final response.

DUE DATE: Your assignments must be complete and to Mr. McSwain by July 13, 1989.

Mr. Deffenbaugh and Mr. McSwain will provide additional instructions. The contact point for the Committee on this request will be Mr. Michael Mahsetky, Chief, Legislative Staff, 443-1116.

Robert A. Marsland

Attachment

cc: Dr. Rhoades
Mr. Singyke
Mr. Roach, OAM

Exhibit #13

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Indian Health Service

Memorandum

Date JUL 3 1989

From Director
Division of Resources Management

Subject Request for Data from the Senate Investigating Committee

To All Area Offices
Attention: Financial Management Officers

The Indian Health Service is in receipt of a request for data on travel from the subject committee. I have been assigned the responsibility for the gathering and indexing of the data. In order to comply with this directive you are required to provide the following:

- Copies of all travel orders and travel vouchers with supporting documentation for claimed amount for all Area participants and any purchases orders/contracts for services related to the meeting if held in your Area of responsibility for the following types of meetings:

  All national or regional conferences or meetings called by the Director and sponsored by IHS principally for policy formulation, program oversight, or program planning that required participation by the Director, Deputy Directors, or CAAD's for a period of 3 working days or more.

  All health promotion/disease prevention (HP/DP) conferences paid for by IHS whether areawide or nationwide. (Determination will be made by Headquarters concerning submission.)

  NOTE: If tribal participants attended and were reimbursed by IHS, provide documentation if other than travel voucher were used.

The required documentation stated above will be provided for the period Fiscal Year 1986 to the present. The documentation will be packaged in folders with a separate folder(s) for each specific meeting. The folder(s) will be labeled as follows:

_____
(PURPOSE OF MEETING)

_____
(DATES OF MEETING)

_____
(COST)

Page 2 - Request for Data from the Senate Investigating Committee

NOTE: Provide a listing of funding source(s) (sub-subactivity) in the front of each folder.

This documentation will be forwarded by overnight mail or whatever is most expeditious to:

James Dunnick
5600 Fishers Lane
Room 5A-38
Rockville, Maryland 20857

THIS WILL BE ACCOMPLISHED IN ORDER TO GUARANTEE RECEIPT IN MY OFFICE BY NO LATER THAN COB, JULY 11, 1989.

Also, by WANG you will provide the following by the same date:

- Determine what additional records are available on the above for the period of time back to January 1, 1982 (prior to FY 86).
  - State where records are (e.g., records center).
  - Time to obtain records.
  - Time needed to review and provide as above requirements state.
- Estimated cost of providing for this request:
  - FY 1986 to present.
  - January 1, 1982 through FY 1985
  - For both, show man-hours expended, overtime costs, copying costs, shipping costs, etc.

There cannot be any extensions of time. It is imperative that each Area Office maintains a complete set of the records submitted in case of questions, they are misplace, etc.

If you have any questions, please contact me.

James P. Dunnick, Jr.
James P. Dunnick, Jr.

Exhibit #14

SELECT COMMITTEE ON INDIAN AFFAIRS
DANIEL K. INOUYE HAWAII, CHAIRMAN
JOHN MCCAIN, VICE-CHAIRMAN

SPECIAL COMMITTEE ON INVESTIGATION
DENNIS DECONCINI, ARIZONA, CHAIRMAN
JOHN MCCAIN, ARIZONA, CO-CHAIRMAN
THOMAS A. BRUNCH, SOUTH DAKOTA
KENNETH M. BALLEN, CHIEF COUNSEL

United States Senate

WASHINGTON, DC 20510-6450

July 11, 1989

Dr. Everett R. Rhoades
Director
Indian Health Service
Parklawn Building
Room 5A-55
5600 Fishers Lane
Rockville, Maryland 20857

Dear Dr. Rhoades:

I understand that Robert Marsland, your Deputy Director for Headquarters Operations, telephoned Sam Hirsch of our staff last Thursday, July 6, to discuss the Special Committee's document request of June 23, 1989. Pursuant to a request from Mr. Marsland, Mr. Hirsch clarified item 4 which read:

> "4. For the period January 1, 1982 to the present, please provide all records, reflecting expenses or costs of any nature whatsoever, for any and all area director's meetings, Council of Associate and Area Directors meetings, HP/DP conferences, and all other meetings, conferences, retreats, etc. where the Director of IHS, the Deputy Directors of IHS, or any of the Area Directors, were present for a period of 24 hours or longer. Such records shall include all records of hotel, motel, airline and other travel and entertainment for the meeting and for all participants in such meetings. With respect to HP/DP conferences alone, please provide such records only if expenses for the HP/DP conference exceeded $50,000 for the individual conference."

Mr. Hirsch and Mr. Marsland agreed to interpret the reference to 24 hours or longer as clock hours (i.e., one overnight), not working hours. They also agreed to narrow the request to only cover meetings, conferences, retreats, etc. attended by at least two of the specified people, i.e., two Area Directors, or an Area Director and a Deputy Director, etc. They thereby eliminated the need to produce documents concerning meetings attended by only one top-level IHS employee.

Mr. Hirsch and Mr. Marsland also confirmed a conversation of the previous week that took place between Mr. Hirsch and Mr. Rich McCloskey of your Division of Legislation and Regulations. Mr. McCloskey indicated that documents dated prior to fiscal year

1987 would have to be retrieved from GSA federal records centers, which could take several weeks. Mr. Hirsch said that was fine, as long as IHS made its request to GSA as soon as possible. Because IHS can produce documents from fiscal years 1987, 1988 and 1989 internally, those documents will be delivered to the Special Committee no later than July 21.

We understand from Mr. Marsland that IHS has no other questions or problems concerning our letter of June 23. Therefore, the Committee looks forward to receiving all of the documents requested in that letter (with the possible exception of those obtained from GSA) on or before Friday, July 21, 1989.

Thank you for your time and effort.

Sincerely,

Kenneth M. Ballen
Chief Counsel

cc: Mr. Bob Marsland
Mr. Gerald L. Olson

DEPARTMENT OF HEALTH & HUMAN SERVICES

Exhibit #15
Public Health Service

Indian Health Service
Rockville MD 20857

AUG 10 1989

Sam Hirsch, Investigator
Special Committee on Investigations
Select Committee on Indian Affairs
United States Senate
Washington, D.C. 20510-6450

Dear Mr. Hirsch:

This will confirm our telephone discussion of August 3, 1989, regarding the letter Mr. Ken Ballen sent to Dr. Everett Rhoades on August 2.

The purpose of the call was to ensure that there was full understanding on our part of Mr. Ballen's request, and understanding on your part as to what we had submitted and what documents were still to be delivered.

The five issues regarding the extent to which the requested documents had been furnished, as stated in your letter of August 2, were discussed item by item to make certain that we had a common understanding.

Item 1. "Documents reflecting expenses or costs other than participant transportation and lodging . . ."

Additional documents are being collected as a result of our defining a 24-hour meeting as workhours rather than clockhours. You and I discussed this and other items on June 29. As a result, we are collecting the additional documents relating to meetings and conferences as defined in our conversation and confirmed on July 11 by Mr. Ballen. We discussed the absence of purchase orders, contract modifications, or other related expenses for meetings held outside of Rockville.

I indicated that the usual practice of Indian Health Service (IHS) Area Office staff is to seek out meeting facilities where conference space is free if a certain number of participants stay in the hotel, motel, or conference facility; or, at times, tribally owned facilities or other Federal space is utilized. Most Area staff use their own audiovisual equipment or, frequently, such equipment is also available at no cost from the host facility.

We stated that, to our knowledge, we have provided all documentation that is available for related conference expenses.

You indicated that you wanted written statements that describe the extent of the documents provided, and statements of the extent free space and equipment has been utilized.

We agreed to provide the written statements and to conduct one more query in an effort to collect any related meeting and conference expenses that may have been overlooked in our first submission.

Item 2. Other documents such as, but not limited to, relevant purchase orders and contracts, or contract modifications related to such conferences or meetings.

Except for the additional documents being collected, to the best of our knowledge, we have provided all of the documents and information requested. We indicated that it is an exception for Area Offices to use tribal contracts as a means to purchase meeting or conference space, and we believe this to have been a limited practice. We have already doublechecked with Area finance and procurement offices, and we agreed to make another query to ensure we have captured all of the documents available.

We also agreed to provide written statements as to the scope of the documents provided.

Item 3. "Documents reflecting expenses or costs for participants other than IHS employees . . ." To the best or our knowledge, except for the additional documents being collected, we have provided all of the documents available from IHS.

Expense documents for tribal employees, tribal chairmen, councilmen, tribal consultants, etc., are not in our custody nor would they be available unless they result from IHS contract modifications or purchase orders. Even if expenses are incurred by tribal employees under Public Law 93-638, contract invoices submitted to IHS for reimbursement under the new simplification rules list expenses by major cost categories only, and backup documentation for individuals is available only from the tribal contractor. Where such documentation is available to us, we have provided it or will provide it in our next submission.

You stated that you did not want us to go to the tribal contractors to retrieve such documentation; that if you wanted it, you would request it.

Item 4. Conferences or meetings financed by IHS but paid through contractors, tribes, and/or tribal organizations.

To a great extent, what is true for Item 3 is true for Item 4. Using tribal contractors to pay for IHS meetings and conferences is not a common practice and is now prohibited by IHS unless the meeting or conference is essential for the contractor to carry out his scope of work. To the extent that this practice has occurred, we have provided and will continue to provide the documentation.

Page 3 - Sam Hirsch, Investigator

Item 5. Documents reflecting excessive cost of Health Prevention/ Disease Promotion (HP/DP). We agreed to look at this item again. We believe we have provided that information where costs other than travel and per diem were incurred. The largest HP/DP conferences were in Phoenix and Albuquerque.

You mentioned Sunrise Springs and the documents surrounding that conference. We did not include documents for this conference because we thought you were already in possession of all the documents relating to the conference. We had provided them to the Office of the Inspector General for investigation prior to the May 15 hearing and the conference was a prominent part of testimony provided.

We talked about the FY 1987 records not included for Bemidji and Aberdeen Area Offices in our July 20 submission. Mr. Dunnick stated that those records were in the Denver Records Center, had been recalled, and will be included in our next submission.

Mr. Dunnick also stated that we had "faxed" a copy of SGM 89-2 to you the evening of August 2, 1989.

I believe this is an accurate description of our discussion.

Robert A. Marsland
Assistant Surgeon General
Director of Headquarters Operations

Enclosures

Exhibit #16

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Indian Health Service

Memorandum

Date AUG 4 1989

From Director of Headquarters Operations

Subject Documents Required by the Special Committee on Investigations - ACTION

To All Area Directors

On June 20, the Indian Health Service (IHS) submitted the first phase of documents to the Special Committee on Investigations of the Senate Select Committee on Indian Affairs. As agreed upon, phase two of our submission will be forwarded on September 15, 1989.

The IHS submitted financial documents for the fiscal years (FY) 1987, 1988, and 1989 to the present, for the Council of Area and Associate Directors meetings, National Indian Health Service/Tribal Consultations meetings, and Health Promotion/Disease Prevention meetings exceeding $50,000. Documents prior to FY 1987 were subject to retrieval from Federal Records Centers (FRC's). Accordingly, you are required to provide phase two documents (January 1, 1982 through FY 1989 to the present) no later than COB Wednesday, August 30, 1989. (See attached for specific instructions.) DO NOT RESUBMIT materials previously provided.

There is a possibility that some records may have been inadvertently destroyed according to FRC instructions and procedures or as a result of mislabeling of documents originally sent to the centers or as a result of some other event. In those instances, you must provide evidence of such disposition. A statement from the FRC or other appropriate official is required.

Please advise in writing, as early as possible, any problems you encounter in providing the requested documents. In addition, please provide, as before, the cost incurred with this request. If you have any questions regarding the above, please call Mr. Jim Dunnick or Mr. Ron Black on FTS 443-1118.

Robert A. Marsland
Assistant Surgeon General

Attachment:
Instructions with Enclosures A and B

Attachment

Instructions

For the records that are available please provide copies of the financial documents for any and all meetings that:

- The Director, IHS, was in attendance for a period of 24 hours (overnight) or more;

and/or

- The Deputy Director, IHS, was in attendance for a period of 24 hours (overnight) or more;

and/or

- An Area Director was in attendance for a period or 24 hours (overnight) or more.

These records will include copies of all documentation to support costs of a meeting and include:

- Travel vouchers for all participants whether IHS or tribal personnel.
- Contract modifications, for costs of tribal personnel, hotel conference rooms, equipment, etc.
- Contracts and/or purchase orders specifically issued to pay costs associated with a meeting sponsored by your Area Office (i.e., hotel conference rooms, consultants, speakers, equipment, tribal representatives, etc.).

Besides the above, Enclosure A is provided for your signature to ensure to the Special Committee on Investigations that all records are being provided.

A separate folder for each meeting with a label showing date, location, and total cost, and a worksheet showing cost by sub-subactivity is required (Enclosure B).

Submission will be packaged by Fiscal Year by date starting with October 1.

The label will not be affixed to the folder but on the inside of the folder.

Enclosure A

Director

(Area Office)

Costs Other Than Travel and Per Diem

For the Record

Any and all documents for Area sponsored meetings reflecting costs are herewith provided.

(Print name and sign)

Enclosure B

LABEL

_____
(Type of Meeting)

_____
(Date)

_____
(Location)

_____
(Cost)

WORKSHEET

Area Office _____ _____
Location (Date)

Sub-subactivity Cost

Instructions for Enclosure 8

Type of Meeting - Purpose of meeting on this line; i.e., CAAD, SUD Meeting, Tribal Consultation, etc.

Date - Provide date(s) of the meeting; i.e., September 7 - 11, 1987, etc.

Location - Provide both city and state.

Cost - Total cost will be reflected on the label and cost by sub-subactivity on the worksheet.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

Date MAY 5 1989

Exhibit #17

From Director

Subject U.S. Senate Investigation of IHS

To Area Directors
Associate Directors

The Senate Special Committee on Investigations of the Select Committee on Indian Affairs has been investigating possible wrong-doing in the administration of Federal programs to Indian people. Senator Dennis DeConcini and Senator John McCain of Arizona chair the Special Committee on Investigations.

The investigations have been ongoing for the last ye[illegible]. Earlier this year, the Committee held hearings on corruption in tr[illegible]l governments, the Bureau of Indian Affairs, and other areas related to services to tribes. The Special Committee is now turning its attention to investigating the Indian Health Service (IHS) for possible problems and weaknesses in the areas of contracting. While the Committee's investigation is currently focused on the Oklahoma City and Nashville Area Offices of IHS, it is not limited to these areas.

The IHS is fully committed to cooperation with the Special Committee on Investigation and will assist in every way possible. During the course of the investigation, staff members of the Special Committee on Investigation will be visiting various IHS offices to review records and to interview various IHS personnel. I would expect all IHS personnel contacted to cooperate with Committee Staff. It is my intention to take whatever steps are appropriate to correct any problems and weaknesses uncovered in order to assure a more effective program.

If you are contacted and are unclear as to what your responsibilities are, you may contact Mr. Michael Mahsetky, Chief, Legislative Staff at IHS headquarters, at (301) 443-1116/FTS: 443-1116, Room 8A-23. You may also contact the Department's Regional Attorney serving your location for clarification of your personal rights pertaining to such c[illegible]mmunication. Should you receive a subpoena you should certainly notify the Office of General Counsel. If for any reason you believe you may personally be the target of the investigation, you may want to consider contacting a private attorney.

Headquarters staff has established a working relationship with the Special Committee on Investigations whereby they will minimize sudden or surprise visits to field and area offices so as not to disrupt office functions and work schedules. In addition, they will a[illegible]ise IHS legislative staff regarding special requests for copies of documents, reports, etc. If

copies of documents are requested by Committee staff, the procedure would be to forward the document(s) to IHS Legislative staff, who will then forward them on to the Committee. The IHS wants to help maintain the confidentiality of any documents or correspondence where necessary to ensure privacy of patient records, etc. It is within this spirit that I approach IHS' participation and cooperation in bringing this investigation to a swift and successful completion. This can be accomplished with your assistance.

Please see that each employee under your direction receives a copy of this memorandum.

Everett R. Rhoades, M.D.
Assistant Surgeon General

Memorandum

Date : MAY 18 1989

Exhibit #18

From : Director

Subject : Cooperation with the Senate Special Committee on Investigation

To : All IHS Employees

On May 5, I sent each Associate Director and Area Director a memorandum calling for full cooperation with the Senate Special Committee on Investigations of the Select Committee on Indian Affairs. I also directed that a copy of this memorandum was to be distributed to each Indian Health Service (IHS) employee. Attached is a copy of the May 5 memorandum.

At the May 15 hearing, the Committee strongly complained that IHS had not adequately informed its employees to fully cooperate with the Committee's efforts and that a possible witness may have been subjected to pressure to not fully cooperate with the Committee.

The purpose of this memorandum is to clarify any misunderstandings as to your rights and obligations:

IHS employees are free to meet with Committee investigators;

You have the right to come forward on your own to speak to or contact the Committee on any issue you believe merits their attention;

You are not required to inform your supervisors of any contact made with the Committee;

You are not in any way to pressure or intimidate others not to cooperate with or testify before the Committee;

All employees should give their full cooperation to the Committee without fear of reprisals from your supervisor or other employees. No one is to interfere with the Committee's work.

I also would like to call to your attention the Civil Service Reform Act which guarantees the right of Federal employees to provide to the Congress, on a confidential basis, information that they believe to evidence:

a violation of any law, rule, or regulation;
mismanagement;

a gross waste of funds;

an abuse of authority; or

a substantial and specific danger to public health and safety.

Thank you for your cooperation in this critically important matter.

Everett R. Rhoades, M.D.
Assistant Surgeon General

Attachment

Exhibit #19

D. ..RTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 2085?

The Honorable Dennis DeConcini
Chairman, Special Committee on Investigations
United States Senate
Washington, D.C. 20510-6450

Dear Mr. Chairman:

I wish to express my serious concern about the outcome of your May 15, 1989, hearing of the Special Committee on Investigations. The Indian Health Service (IHS) is known for its responsiveness to congressional inquiries, and we have approached the current hearings in the same spirit of cooperation.

Although it is true the IHS has not yet been able to supply your investigators with all the documentation requested, our staffs have been in frequent communication and your representatives were made aware of problems we were encountering in collecting documents. In fact, during one such discussion, we were given the impression by your staff that you had obtained much of the requested information during your on-site investigations and would be able to proceed with your hearings based on the material you already had. Therefore, I do not believe that it was fair to conclude that the IHS was being "singularly uncooperative" or not taking the investigation seriously. To the contrary, we already have invested considerable resources in assembling the requested documents, and are continuing with this effort. We will supply the remaining information promptly and in usable form.

You also noted at the hearing that you have had difficulty in gaining access to lower level employees and that you had information suggesting that a witness may have been subjected to pressure not to cooperate fully with the Committee. I am at a loss to understand the basis for those statements. Certainly, had you shared them with me, I would have remedied the situation immediately. I have made it clear from the beginning of this investigation that IHS employees were to cooperate with the Committee. On May 5, I reiterated my position to all Area Directors and Associate Directors in a memorandum which stated:

> "The IHS is fully committed to cooperation with the Special Committee on Investigations and will assist in every way possible. During the course of the investigation, staff members of the Special Committee on Investigations will be visiting various IHS offices

to review records and to interview various IHS personnel. I would expect all IHS personnel contacted to cooperate with the Committee staff. It is my intention to take whatever steps are appropriate to correct any problems and weaknesses uncovered in order to assure a more effective program."

This memorandum was distributed to all IHS employees. In further response to your concerns, I am sending another memorandum to all Indian Health employees instructing them to cooperate with the Committee.

In addition, on several other occasions, I have advised my senior staff that they are to do nothing that could reasonably be construed as intimidating any employee who wished to speak with the Committee. Allegations that potential witnesses have been intimidated imply direct contradiction of my clear instructions. If you will provide me with the specific evidence on which you base your charge, I will take appropriate remedial action at once.

I wish to make one last and most important point. Although you stated that the Committee could not proceed with its May 15 hearing because IHS had not provided adequate information, members did not feel constrained from suggesting pervasive fraud within the IHS. There is no evidence to support these charges. Cancelling the session of the hearing during which IHS could have presented its views and responded to allegations creates an unfair and inaccurate impression.

In closing, I wish to observe that in the past the IHS and your office have worked together to the general betterment of the health of Indian people. It is important to make every effort not to do serious damage to that common goal. Accordingly, I wish to emphasize that IHS should be provided with a full and fair opportunity to respond to the Committee's concerns.

Sincerely yours,

Everett R. Rhoades, M.D.
Assistant Surgeon General
Director